VAN NATTA'S
WORKERS' COMPENSATION REPORTER

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(Pages 1421-2054)

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)

In the Matter of the Compensation of
ROLAND DIR, Applicant
WCB Case No. CV-92001
FINDINGS OF FACT, CONCLUSIONS AND PROPOSED ORDER (CRIME VICTIM ACT)
Michael O. Whitty, Assistant Attorney General

Pursuant to notice, a hearing was conducted and concluded by Roger C. Pearson, special hearings officer, on May 8, 1992 at Salem, Oregon. Applicant, Roland Dir, was present and unrepresented. The Department of Justice Crime Victims' Compensation Program ("Department") was represented by Michael O. Whitty, Assistant Attorney General. Jason Barber, claims examiner, was also present on behalf of the Department. The court reporter was Marlene Cromwell. The record was closed May 8, 1992.

Applicant has requested review by the Workers' Compensation Board of the Department's Findings of Fact, Conclusions and Order on Reconsideration dated November 4, 1991. By its order, the Department denied applicant's claim for compensation, filed pursuant to the Compensation of Crime Victims Act. ORS 147.005 to 147.365. The Department based its denial on the applicant's substantial contribution to his injury through the provocation of his assailant.

FINDINGS OF FACT

On August 2, 1991, applicant filed an application for benefits with the Department, claiming that he had been the victim of a May 26, 1990 assault. Specifically, applicant stated that he had become involved "in small argument with black man and friend . . . man shot me in the head then in the neck and chest."

On August 16, 1991, the Department issued its Findings of Fact, Conclusions and Order. Although it was persuaded that applicant sustained injuries as a result of the assault, the Department concluded that it had not been filed within one year from the date of the incident. Relying on ORS 147.015(6) and OAR 137-76-030, the Department denied the claim for benefits as untimely filed.

On August 27, 1991, applicant requested reconsideration. Noting that he had been in a coma and incapable of completing the application within the required period, applicant sought assistance from the Department in fulfilling his financial obligations.

Thereafter, the Department began a further investigation. On September 10, 1991, applicant submitted a written statement which provided the following account. After pulling into a convenience store, applicant became embroiled in an argument with two men over a parking space. After a "couple minutes" of argument in which applicant was "threaten[ed]," one of the men attempted to remove a shovel from applicant's truck. As applicant "tried to get the shovel back from them[,] the other guy pulled a shot gun out of his trunk and shot me."

On September 18, 1991, the Department issued another decision, making the following findings. As applicant pulled into the convenience store, the suspect ("John Norman") and a friend were using the public telephone in front of the store. Applicant, who was extremely intoxicated (his blood alcohol content was later found to be .346), began yelling profanities and racial slurs at the two individuals. A verbal altercation ensued. Eventually, applicant took a shovel from his vehicle and smashed the window in Norman's vehicle. Thereafter, Norman removed a shotgun from the trunk of his vehicle and shot applicant, who was approximately 60 to 70 yards away.

Based on the aforementioned findings, the Department reached the following conclusions. Although it was apparent that applicant had sustained injuries as a result of the assault, the Department was persuaded that applicant had substantially provoked his assailant. Consequently, relying on ORS 147.125(3), the Department denied applicant's claim for benefits.

On October 11, 1991, the Department received applicant's request for further consideration of its decision. Asserting that the manager of the convenience store agreed with his version of the incident, applicant once again sought benefits.

On October 30, 1991, the Department received several incident reports from the City of Portland Police Bureau. Officer Jensen conducted the initial investigation at the scene of the incident. He interviewed two clerks (Baker and Brennecke), who were working at the convenience store.

Baker recalled that two black males were using the pay phone outside of the store, when applicant drove up in his truck. Applicant and the black men began arguing, eventually resulting in applicant removing his shirt and "kick[ing] in the air." The black men then took shovels from the back of applicant's truck, prompting applicant to exclaim that "you black guys never fight fair." In response, the black men laughed at applicant, telling him that he was drunk. At this point, Baker went outside to calm the situation, persuading the black men to return the shovels and shake hands with applicant.

Notwithstanding this temporary resolution of hostilities, Baker recalled that applicant and one of the black men (later determined to be George Waters) resumed their dispute. When applicant grabbed a shovel, Waters began running down the street. Applicant gave chase, at which time Baker suggested to the other black man (later determined to be Jonathan Norman) that "you better go get him [Waters] and pick him up." Norman agreed and got into his vehicle and went after applicant and Waters. Baker recalled that in passing applicant, Norman "swung out into the oncoming traffic so as not to strike him." Thereafter, Baker saw applicant returning to the store, with the black men throwing bottles toward him. Although Baker did not observe applicant's next action, Brennecke told Baker that applicant had broken out Norman's car window. A short time later, Baker heard a gun shot.

In Baker's opinion, the black men had not wanted to get involved. In particular, Baker had been asked by one of the men "why don't you get him in the store so we can get out of here."

Brennecke also recalled that the argument began soon after applicant drove into the store's parking lot. Brennecke heard applicant use the word "niggers." He also observed applicant removing his shirt and, while the black men were standing still, make an "uncoordinated karate kick, which did not come close to hitting" either man. When applicant stumbled and fell, the black men took shovels from applicant's truck, but did not strike applicant with them. It was at this point that Baker went outside, the shovels were returned to the truck, and everyone shook hands.

The next thing that Brennecke saw was applicant with a shovel chasing Waters down the street. Brennecke then observed Norman get into his car and drive after them. Brennecke noted that the car swerved to avoid hitting applicant. Waters attempted to get into the car. However, with applicant continuing to pursue him, he was unable to do so. At this point, both black men threw bottles at applicant. Then applicant struck the side window of the car with the shovel, breaking the glass. Norman, who had returned to the car after throwing a bottle, again left the vehicle. Shortly thereafter, Brennecke heard the gunshot.

Officer Anderson also conducted an investigation, interviewing Melissa Kelly and Christy McLeod. These witnesses had been in a vehicle which was stopped at a nearby red light when the shooting occurred. They were interviewed separately and gave consistent versions of the event. The witnesses saw a white man (applicant) "holding a shovel in a threatening manner" toward a black man (Waters), who was holding a bottle of beer "in a threatening manner." The men were arguing. Waters appeared to be trying to "escape" into the front passenger seat of a car which was slowly moving down the street. However, every time Waters advanced toward the car, applicant moved toward him with the shovel.

Eventually, according to Kelly and McLeod, Waters threw the beer bottle at applicant, at which time applicant struck the front passenger side window of the car with the shovel. At this point, the driver of the car (Norman) got out and threw a can of root beer at applicant. Norman then "calmly walked to his trunk and opened it." He removed an object from the trunk and pointed it at applicant. When they heard the shot, Kelly and McLeod realized that the object was a gun. Until the shooting, the women "originally thought that the argument was not very serious."

Officer Kruger interviewed several witnesses who resided near the shooting scene. From inside his residence, Robert Smith saw applicant holding a shovel and arguing with Waters. After Waters threw a beer bottle at applicant, he got into the front passenger's side of Norman's car. Smith also saw Norman get out of the driver's side of the car, throw a bottle at applicant and return to the car. At this

point, applicant advanced to the car and broke out the passenger's window with his shovel. Norman drove the car approximately 40 feet up the street and stopped. Waters exitted the car and began moving back towards applicant, who had moved to the sidewalk. Norman also exitted the car and told Waters to return. Exclaiming "you really f____-up now," Norman opened the trunk of his car, removed a shotgun, and fired one round from the hip at applicant.

Sophia Frison and Lisa Shenk were with Smith at the time of the shooting. According to Officer Kruger's report, Frison's recollection of the events was "identical" to Smith's account. In addition, Shenk's description "matched" Smith's version, but was less detailed.

Approximately one week after the shooting, Detective Findling interviewed Norman, who provided the following account of the events that night. While using the pay phone at the convenience store, Norman noticed applicant drive up in his truck. Norman then heard applicant speaking to him and his friend (Waters) in a racial and derogatory manner. When Norman told applicant to go into the store because they did not want any trouble, applicant became more belligerent. After applicant tried to kick Waters, Waters picked up a shovel from applicant's truck, and the store clerk (Baker) came out and told applicant to come into the store. It was at this point that Waters put the shovel down, and Baker attempted to get applicant and Waters to shake hands. However, Waters drew back because he believed applicant was trying to pull him towards applicant.

Thereafter, applicant started for the store's door, but then turned toward Norman who was still on the phone. Waters then struck applicant on the face, prompting applicant to remove his shirt. When applicant got within arm's length of him, Norman pushed him back. Baker, the store clerk, then offered Norman a quarter to use another pay phone. When Norman agreed, applicant grabbed a shovel and attempted to strike Norman. After missing Norman, applicant began chasing Waters down the street. Baker then gave Norman the quarter and suggested that he pick up his friend.

Norman drove down the street, swerving to avoid applicant. As Norman pulled up to let Waters in, applicant came at Waters with the shovel. When Waters backed off, applicant hit the passenger side window with the shovel. Norman drove forward and stopped the car to let Waters in. Upset and scared, Norman got out of the car, went to the trunk, and removed the shotgun. Norman recalled applicant moving toward him, at which time Norman fired. Although Norman stated that he aimed low, Detective Findling noted that applicant's wounds were from his lower rib cage to the top of the head.

Detective Findling also interviewed Sophia Frison, who observed the incident from Robert Smith's residence. Frison recalled that after Waters threw a beer bottle at applicant, applicant ran toward the car with the shovel in his hands. At that point, Norman got out of the car and threw a beer bottle at applicant. When applicant backed up, Norman got back into the car. Waters had not returned to the car. Applicant than ran toward the car and struck the passenger side window with a shovel. After striking the window, applicant "backed up to a nearby telephone pole." Thereafter, Norman left the car, opened the trunk, removed the shotgun, and shot applicant. Frison believed that Waters was "really trying to get away from [applicant] but that he did go back at [applicant] when the window was broken."

Detective Findling interviewed Robert Smith. Smith recalled that, after the two men threw bottles at him, applicant went to the car and broke out the window.

Detective Findling also was contacted by Christine Enold. Enold had last seen applicant at 6:45 p.m., approximately 9 hours before the shooting. When she last saw applicant, he was intending to return to a residence after watching the first half of a basketball game. Enold stated that applicant was "an alcoholic but had stopped drinking recently." Describing applicant as normally "very easy going," Enold noted that "he did have a loud mouth and seemed to show off when he was drinking."

Detective Jensen interviewed George Waters, the passenger in Norman's car. Waters stated that applicant approached them while they stood near a telephone booth. Applicant stated "what are you looking at?" and "you niggers must want to fight?" Waters admitted striking applicant, but only after he had been kicked in the knee. After the store clerk had attempted to resolve the dispute, applicant had grabbed the shovel and eventually started chasing Waters down the street. Waters, who was holding a

Gatorade bottle and a Root Beer cup, called to Norman to come pick him up. At that point, Norman drove toward Waters and Waters threw the Gatorade bottle at applicant.

When Norman pulled the car to a position where Waters could get in, applicant charged the car, struck the passenger side window with the shovel, and poked at Norman with the end of the shovel. Norman drove the car forward, stopped, got out of the car, and removed the gun from the trunk. Norman asked applicant why he had broken the window. At that time Waters recalled that applicant "began to 'walk' towards Norman's position carrying the shovel in a 'port arms' position." Norman fired when they were approximately 30 feet apart. In Waters' opinion, Norman had shot applicant because he "'probably didn't want to take anymore chances' with [applicant], and that he was angry about having his car damaged."

On November 4, 1991, the Department issued its Order on Reconsideration. After reviewing the police reports (including statements from the store clerks, the two occupants of the vehicle stopped at the red light, and the three residents), the Department found some slight discrepancies concerning its September 19, 1991 findings of fact. Nevertheless, reasoning that there was no basis for reversing its prior conclusion, the Department adhered to its decision that applicant was not entitled to benefits because he had substantially contributed to his injuries by provoking his assailant.

Thereafter, applicant requested Board review of the Department's Order on Reconsideration. Contending that "all confrontations or arguments that had taken place were resolved" and that he "was standing in the parking lot and was then shot," applicant sought reversal of the Department's decision.

CONCLUSIONS OF LAW

The standard of review for cass appealed to the Board under the Act is de novo on the entire record. ORS 147.155(5); Jill M. Gabriel, 35 Van Natta 1224, 1226 (1983).

Pursuant to ORS 147.015(5), applicant is entitled to an award under the Act, if, the death or injury to the victim was not substantially attributable to the wrongful act of the victim or substantial provocation of the assailant of the victim. The Department shall determine the degree or extent to which the victim's acts or conduct provoked or contributed to the injuries or death of the victim, and shall reduce or deny the award of compensation. ORS 147.125(3).

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

After closely and carefully observing applicant's attitude and demeanor while testifying, I detected nothing which would cause me to doubt his credibility. Nevertheless, in light of uncontradicted reports establishing that his blood alcohol level was .346 and considering that his recollection of the events surrounding his injury is inconsistent with the observations of several uninterested witnesses as well as his prior written accounts, I do not consider his testimony to be reliable. Therefore, in reaching my conclusions, I rely on the written record.

My conclusion that claimant's testimony was inconsistent with the record and his prior statements is based on the following reasons. To begin, claimant testified that the altercation began when the two black men drove into the parking lot and confronted him over the use of the telephone. However, in seeking reconsideration of the Department's decision, he had stated that the dispute arose over a parking space. Moreover, the two store clerks who observed the argument recalled that: (1) the two black men had arrived first; (2) applicant began uttering profanities and racial slurs; and (3) applicant removed his shirt and began kicking toward the black men. One of clerks (Baker) further concluded that the two black men had not wished to get involved with applicant and one of them had requested that Baker try to get applicant into the store so they could leave without further trouble.

Secondly, applicant recalled that the shooting occurred some 15 feet from the store. Yet, both store clerks recounted that the shooting incident occurred down the street which adjoined the store's

parking lot. Because of the location of the shooting, the clerks were unable to observe the shooting. Furthermore, witnesses at the red light, as well as the nearby residences, stated that Norman's car continued to slowly proceed down the street and, after the "broken window" incident, moved another 40 feet before stopping.

In addition, applicant testified that he struck the driver side window of the vehicle with the shovel. This statement is directly contrary to the statements from the women who were parked at the adjoining intersection, as well as a nearby resident (Smith), who stated that applicant struck the passenger side window.

Finally, applicant recalled that he was retreating towards the store when he was shot. This testimony is directly contrary to his September 1991 written statement which he submitted to the Department. At that time, applicant stated that he was shot when he tried to retrieve his shovel from the men. Moreover, other than a reference to backing up to a nearby telephone pole on the sidewalk following the "shovel" incident, none of the witnesses' statements supports applicant's recollection.

Turning to a review of the record, I conclude that applicant's injuries were substantially attributable to his own wrongful act and that he substantially provoked his assailant. This conclusion is based on my observation that at each stage of this unfortunate incident, applicant behaved in a manner which substantially contributed to the escalation of emotions and violent actions.

Specifically, applicant initiated the altercation by verbally accosting the two black men. After the store clerk had reduced the initial tensions and the shovels had been returned to applicant's truck, applicant reincited the exchange by grabbing the shovel and pursuing Waters down the street. In addition, after Norman attempted to retrieve Waters, applicant prevented Waters from entering Norman's vehicle by brandishing the shovel in a threatening manner. Eventually, applicant further escalated the encounter by striking the passenger side window of Norman's car with the shovel.

Applicant does not contest the fact that his blood alcohol content the night of the shooting was recorded at .346. He also acknowledges that he participated in a heated disagreement and physical confrontation, which included his striking a window of his assailant's vehicle with a shovel. Nevertheless, applicant contends that these exchanges and confrontations had been resolved by the time of the shooting. In particular, he asserts that he was shot some 5 minutes after the "shovel" incident and that he was retreating from the area when he was shot.

The record does not corroborate applicant's account of the incident. As previously discussed, applicant's testimonial version of events is contradicted by his own prior written statement which claimed that he was shot while attempting to retrieve his shovel. Furthermore, by the witnesses' accounts, the shooting occurred after Norman had driven his car approximately 40 additional feet, exitted the vehicle, and removed a shotgun from the trunk. There is no suggestion that there was a noteworthy delay between the "shovel" incident and the shooting. In addition, other than a reference to applicant backing up to a nearby telephone pole on the sidewalk, there is no indication that he was extricating himself from the area at the time of the shooting. In fact, had applicant been leaving the scene as he now contends, it is reasonable to assume that in 5 minutes time he would have been beyond the range of a shotgun blast.

My review of the record does not lead me to a conclusion that the shooting was an isolated incident which should be considered separately from the immediately preceding events. Notwithstanding the dramatic escalation of violence occasioned by the use of a firearm, the fact remains that this unfortunate incident was prompted by applicant's voluntary and unlawful assault and aggressive behavior. Therefore, I hold that the injuries applicant has suffered are substantially attributable to his own wrongful actions. I am further persuaded that applicant's conduct leading to the shooting constitutes substantial provocation of his assailant.

My conclusion should not be interpreted as condoning the conduct exemplified by applicant's assailant. To the contrary, such an act of violence is deplorable and, I trust, the assailant has been punished to the fullest extent of the law. Nevertheless, to receive benefits as a victim of a crime under the Act, the legislature has required that applicant's injury must not be substantially attributable to his own wrongful act or his substantial provocation of his assailant. For the reasons discussed above, I have

concluded that applicant's conduct constitutes substantial contribution and/or provocation. Consequently, I am obligated to conclude that applicant's claim does not satisfy the statutory requirements which would entitle him to benefits under the Act.

In conclusion, the physical and financial trauma caused by this tragic event is apparent. However, the legislature has mandated that several specific requirements be met before applicant can recover benefits. For the reasons detailed above, one of these requirements has not been satisfied. Accordingly, his claim for benefits must be denied.

PROPOSED ORDER

I recommend that the Findings of Fact, Conclusions and Order on Reconsideration of the Department of Justice Crime Victims' Compensation Program dated November 4, 1991 be affirmed.

July 1, 1992 Cite as 44 Van Natta 1426 (1992)

In the Matter of the Compensation of
ROBERT W. INKENBRANDT JR., Claimant
WCB Case No. 91-15335
ORDER DENYING RECONSIDERATION
Merrill Schneider, Claimant Attorney
Cooney, et al., Defense Attorneys

On June 4, 1992, we dismissed the insurer's request for Board Review of Referee Podnar's order that: (1) directed the insurer to pay claimant temporary total disability commencing April 26, 1991; (2) assessed penalties under ORS 656.262(10) for unreasonable claim processing; and (3) awarded an assessed fee for claimant's attorney's efforts in reclassifying the claim from nondisabling to disabling. We took this action in accordance with the parties' "Disputed Claim Settlement," which we also approved on June 4, 1992. The insurer has now submitted a "Request for Board Review" of our June 4, 1992 order. Inasmuch as we have already dismissed the insurer's request for review, we treat its submission as a motion for reconsideration of our dismissal order. We deny the motion.

On June 5, 1992, the Board received the parties' Claim Disposition Agreement (CDA) concerning claimant's December 1990 injury claim. The CDA currently remains pending before the Board. On receipt of the CDA, all other Board proceedings are suspended. OAR 438-09-030(1). Consequently, we are not authorized to take further action regarding this matter. Moreover, even if we were so authorized, we would decline to reconsider our decision because the insurer's request for review was validly dismissed in accordance with the parties' properly approved agreement.

Accordingly, the motion for reconsideration is denied. The parties' rights of appeal shall continue to run from the date of our June 4, 1992 dismissal order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DALE P. BALLOU, Claimant
WCB Case No. 90-21265
ORDER OF ABATEMENT
William H. Skalak, Claimant Attorney
Susan Ebner (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our June 4, 1992 Order on Review that affirmed a Referee's order which set aside its partial denials of claimant's current left hip avascular necrosis and femoral head condition. Contending that we did not intend to find it responsible for claimant's underlying avascular necrosis disease, SAIF asks that we uphold those portions of its denials which denied claimant's underlying aseptic/avascular necrosis condition.

We withdraw our June 4, 1992 order for reconsideration. Before proceeding with our reconsideration, claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, this matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
BARRY M. BRONSON, Claimant
WCB Case No. 90-16125
ORDER ON REVIEW
Ronald A. Fontana, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of those portions of Referee Hoguet's order that: (1) upheld the self-insured employer's denial of claimant's occupational disease claim for a mental condition; and (2) declined to award an independent attorney fee in addition to a penalty for the employer's unreasonable resistance to the payment of compensation. The employer cross-requests review of those portions of the order that: (1) concluded that claimant was entitled to interim compensation from April 9, 1990 through August 28, 1990; and (2) awarded a penalty for its unreasonable resistance to the payment of compensation. On review, the issues are compensability, interim compensation, 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

Compensability

The Referee determined that claimant had a mental disorder generally recognized within the medical community and that the disorder arose out of and in the course of employment. The Referee further determined that, with one minor exception, the stressful conditions existed in a real and objective sense. The Referee concluded, however, that claimant had failed to establish that he was subjected to conditions not generally inherent in every workplace and, accordingly, that his mental disorder claim was not compensable. We agree and adopt the Referee's conclusions. We add the following supplementation.

On review, claimant first contends that the Referee erred in finding that the conditions causing his mental disorder were conditions inherent in every working situation. ORS 656.802(3)(b).

Specifically, he argues that the employer's ban of polystyrene products and its effect on his sales quota of polystyrene food service disposables are not conditions common in every workplace.

In Housing Authority of Portland v. Zimmerly, 108 Or App 596 (1991), the court concluded that, by adding the language limiting compensable claims to those caused by "conditions other than conditions generally inherent in every working situation," the legislature intended to preclude claims for mental disorders that arose from conditions common to all occupations. In this case, we agree with the Referee's determination that, while the polystyrene ban adversely affected claimant's sales, it represented but one example of the regulatory rules and guidelines affecting all jobs. Thus, as noted by the employer, it is inappropriate to focus on the specifics of the ban itself and overlook its general relationship to the workplace. Because operating within everchanging legal parameters is a condition generally inherent in every work place, we do not consider those factors sufficient to establish a compensable claim under ORS 656.802(3)(b).

Claimant next contends that the Referee erred in finding that his perception that his manager had prejudged him did not exist in a real and objective sense. He argues that, regardless of how unreasonable his perception of his manager's conduct may have been, his claim is compensable because he was reacting subjectively to real, potentially stress-causing events.

We agree that the reasonableness of a claimant's perception is irrelevant if the events are, in fact, capable of causing stress. Adsitt v. Clairmont Water District, 79 Or App 1 (1986). Nonetheless, even if the alleged events, viewed objectively, were capable of causing stress, we conclude that the manager's actions, including the January 1990 meeting and two subsequent ride-alongs, were reasonable corrective or job performance evaluation measures. Accordingly, they too cannot be considered as the basis for finding claimant's adjustment disorder compensable.

Interim Compensation

The employer contends that the Referee erred in finding that claimant was entitled to interim compensation from April 9, 1990, the date he first sought treatment, through August 28, 1990, the date of the denial. It contends that May 11, 1990, the date claimant filed his claim, was the date it first had notice of a work related claim and that after April 27, 1990 claimant was away from work for reasons unrelated to his claim.

In Jones v. Emanual Hospital, 280 Or 147 (1977), the Court held that, under the provision of ORS 656.262, an employer or insurer is required to begin payment of interim compensation within 14 days of having notice of a claim. The payments are due regardless of compensability and are intended to prevent delays in processing and insure a worker's well being during the period in which acceptance or denial of the claim was being considered. In Bono v. SAIF, 298 Or 405 (1984), the Court limited the effect of Jones, holding that, because the purpose of interim compensation is to compensate the injured worker for leaving work, compensation is not required if the worker fails to prove that he was away from work for reasons related to the claim.

Turning to the facts of this case, we first conclude that the employer first had notice of the claim on April 10, 1990, the date it received a facsimile indicating that claimant had been taken off work for stress that he attributed to his work. (Ex. 2-4). That knowledge was sufficient to lead a reasonable employer to conclude that workers' compensation liability was a possibility. See Argonaut Ins. v. Mock, 95 Or App 1 (1989); Arthur L. Ennis, 43 Van Natta 1477 (1991). Thus, the employer was required to begin payment of interim compensation on April 24, 1990. We add, however, that Dr. Kepple released claimant from work only through April 27, 1990. (Ex. 4). Thereafter, claimant was away from work for reasons unrelated to his claim, i.e., he had been fired. Accordingly, it follows that he was not entitled to interim compensation after that date. Nix v. SAIF, 80 Or App 656 (1986).

Penalty

The Referee concluded that the employer's unexplained failure to pay interim compensation was unreasonable and, accordingly, imposed a penalty pursuant to ORS 656.262(10). We agree and adopt the Referee's conclusion that the employer's conduct warranted the assessment of a penalty. See Lester

v. Weyerhaeuser, 70 Or App 307 (1984). We add, however, that the penalty shall be limited to an amount equal to 25 percent of interim compensation due under this order.

Attorney Fee

In addition to one-half the assessed penalty for the employer's failure to pay interim compensation, claimant contends that his attorney is entitled to an independent attorney fee under ORS 656.382(1). We disagree. As we recognized in Nicolasa Martinez, 43 Van Natta 1638 (1991), a separate attorney fee is not payable where the alleged basis for the fee is the same that which has been previously penalized under ORS 656.262(10). Thus, claimant's attorney fee is limited to one-half the penalty provided above.

ORDER

The Referee's order dated June 14, 1991, as amended August 2, 1991, is affirmed in part and modified in part. In lieu of the Referee's award of interim compensation and a penalty, the employer is ordered to pay claimant interim compensation from April 24, 1990 through April 27, 1990. For its unreasonable failure to pay interim compensation, the employer is assessed a penalty equal to 25 percent of the interim compensation due. One-half of the penalty is payable to claimant's counsel in lieu of an attorney fee. The remainder of the order is affirmed.

July 2, 1992 Cite as 44 Van Natta 1429 (1992)

In the Matter of the Compensation of
ROBERT A. HANSEN, Claimant
WCB Case No. 91-08397
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Hooton and Brazeau.

Claimant requests review of Referee Peterson's order that declined to direct the SAIF Corporation 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.

FINDINGS OF FACT

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

An April 5, 1990 Determination Order awarded claimant a specified dollar amount of compensation for 14 percent scheduled permanent disability that corresponded to $145 per degree of disability.

Claimant requested a hearing on July 11, 1990 regarding that award. By Stipulation and Order on September 10, 1990, the award was increased by a specified dollar amount of compensation for an additional 5 percent scheduled permanent disability, which corresponded to $145 per degree of disability. The parties agreed that the Stipulation and Order was intended to settle all issues raised or raisable regarding the award of scheduled permanent disability.

On January 2, 1991, more than six months after the April 5, 1990 Determination Order was issued, claimant filed a request for hearing challenging the rate of scheduled disability.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, because claimant stipulated and agreed to an award which corresponded to the rate of $145 per degree, claimant was precluded from subsequently challenging the rate at which his scheduled permanent disability was paid. He, therefore, declined to direct SAIF to pay

claimant's award at the rate of $305 per degree. We affirm the Referee's decision with the following comments.

Subsequent to the Referee's decision, we held in Michael E. Morrison, 44 Van Natta 372 (1992), that because a Determination Order was final and the claimant had stipulated to payment of an additional award at the rate of $145 per degree, the claimant was precluded from subsequently asserting that his award should have been paid at the rate of $305 per degree. There, 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 $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 a rate of $305 per degree.

We find our holding in Morrison to control the present case. The present parties agreed that the September 10, 1990 Stipulation and Order settled all issues raised or raisable. Moreover, the stipulation provided for an award at a specified dollar amount equal to $145 per degree of disability. Therefore, the dollar rate per degree was an issue raised or raisable by the award. Compare Kevin E. Pompe, 44 Van Natta 180 (1992).

Contending that "the parties labored under the mistaken belief that $145 per degree was the correct rate of scheduled PPD," claimant urges us to reform the stipulation and award him $305 per degree of disability. We decline to do so; it is not our function to question the parties' agreement. See Evans v. Rookard, Inc., 85 Or App 213 (1987).

Accordingly, because the April 5, 1990 Determination Order became final by operation of law and claimant stipulated to the payment of the additional award at a specified amount which corresponded to a rate of $145 per degree, claimant is precluded from asserting entitlement to the higher rate.

ORDER

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

July 2, 1992 Cite as 44 Van Natta 1430 (1992)

In the Matter of the Compensation of
PETER O. ODIGHIZUWA, Claimant
WCB Case Nos. 89-11253 & 89-11254
ORDER ON REMAND (REMANDING)
Goldberg & Mechanic, Claimant Attorneys
Roberts, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Tri-Met, Inc. v. Odighizuwa, 112 Or App 159 (1992). The court has reversed that portion of our prior order which found that the employer's denial of claimant's injury claim was unreasonable. In finding the denial unreasonable, we had concluded that the denial was based on the employer's supervisors' version of the accident which we had found not credible. The court reasoned that the knowledge of an agent is imputable to the principal if the knowledge is about matters within the agent's authority. Inasmuch as our order made no findings concerning whether the supervisors' knowledge of the accident could be imputed to the employer on the basis of their authority, the court has remanded for a determination of the scope of the supervisors' authority and whether the employer had a legitimate doubt about its liability.

After conducting our review, we consider the record insufficiently developed to determine whether the supervisors' knowledge of the "true facts" was imputable to the employer. Under such circumstances, we remand for a determination of the scope of the supervisors' authority. ORS 656.295(5). Such a determination will permit the Referee to resolve the issue of whether the employer had a legitimate doubt regarding its liability for claimant's injury claim at the time of its denial.

Accordingly, this matter is remanded to the Presiding Referee with instructions to delegate the case to another Referee. The designated Referee shall conduct further proceedings to make the determinations and conclusions discussed above. Such proceedings may be conducted in any manner that will, in the opinion of the designated Referee, achieve substantial justice. Upon completion of the further proceedings, the designated Referee shall issue a final, appealable order.

IT IS SO ORDERED.

July 6, 1992 Cite as 44 Van Natta 1431 (1992)

In the Matter of the Compensation of
JERRY B. MATHEL, Claimant
WCB Case No. 90-18752
ORDER OF ABATEMENT
Rasmussen & Henry, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

The self-insured employer requests abatement and reconsideration of our June 5, 1992 Order on Review that affirmed the Referee's order setting aside the insurer's denial of claimant's myocardial infarction claim. The employer bases its request on the recent Court of Appeals decision in SAIF v. Hukari, 113 Or App 475 (1992), which holds that "any claim asserting that a condition is independently compensable because it is caused by on-the-job stress, regardless of the suddenness of onset or the unexpected nature of the condition, and regardless of whether the condition is mental or physical, must be treated as a claim for an occupational disease under ORS 656.802." (Emphasis in original.)

In order to consider the employer's motion, we withdraw our June 5, 1992 order. Claimant is granted an opportunity to respond by submitting a response within 14 days from the date of this order. Thereafter, we take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
MIKE YOCHIM, Claimant
WCB Case No. 91-07726
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of those portions of Referee Lipton's order which: (1) found that claimant was entitled to additional temporary disability benefits; and (2) assessed a 25 percent penalty for the employer's allegedly unreasonable resistance to the payment of temporary disability compensation. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant began working for the employer in December 1989. He injured his low back at work on March 1990 and subsequently filed a claim for a low back strain, which the employer denied. By Opinion and Order dated May 14, 1991 (marked in this record as Ex. 30), Referee Mills found the injury claim compensable and set aside the denial (WCB No 90-16778). The employer did not appeal the order, which therefore became final. In setting aside the denial, Referee Mills made the following findings which are relevant to this case:

> "Claimant's job with the employer was to pull parts for deliveries. He had a gradual onset of low back pain. *** He ended up seeing Dr. Bradshaw on March 12, 1990 who diagnosed a low back strain related to claimant's lifting at work. Dr. Bradshaw gave claimant a work restriction limiting him to 20 pounds of lifting from March 12 to March 19 and told him to come back on that date. (Exhibit 1a, 1)
>
> "On March 19, late in the day before getting off work, claimant was rushing to fill some orders. He and a co worker ***were working in the same area. While claimant was not to lift more than 20 pounds he was instructed to fill an order which required him to lift jacks off the floor that did weigh more than 20 pounds. In doing so, claimant's back was again strained and he experienced such excruciating pain that he dropped the jack. [Claimant's co-worker] witnessed this incident.
>
> "That night after work claimant again went to the doctor as he had been instructed. He was still complaining of back pain. (Exhibit 1b). The next morning claimant returned to work. He was told by his employer that he could not work unless he had a full return to work release from his doctor. Claimant went back to his doctor that morning and got such a release (Exhibits 1, 16).
>
> "That same day, March 20, claimant's department manager prepared a personnel data form indicating that claimant had not been hurt on the job but was hurt in [a 1988] motor vehicle accident. Claimant signed off of that form to protect his job. It was not, in fact, true. Claimant had not hurt his back in a motor vehicle accident but had hurt it on the job. (Exhibit 1d). Shortly thereafter, claimant was terminated. (Exhibit 1e). He did not have any funds or benefits and therefore did not continue to obtain medical treatment."

On claimant's return to work following the March 19, 1990 injury, he was unable to perform his job as in the past due to the pain caused by the compensable injury. On March 26, 1990, claimant was fired, as noted above. While the employer's records state that he was terminated because he was too slow and talked too much (Ex. 13C), claimant was terminated because he was physically unable to perform his regular duties due to his compensable injury. Claimant has not worked or received unemployment benefits since his termination.

Dr. Takacs, claimant's treating physician since the fall of 1990, authorized time loss benefits from November 1, 1990 to January 21, 1991. On June 11, 1991, and commencing from that date, Dr. Goldberg, also a treating physician, authorized time loss for 60 days.

The employer paid claimant time loss benefits from November 1, 1990 to January 21, 1991 and from June 11, 1991 through the date of the hearing. Claimant requested a hearing, seeking time loss benefits from March 26, 1990 to June 11, 1991, less time loss benefits paid.

CONCLUSIONS OF LAW AND OPINION

On May 7, 1990, the Governor signed into law Senate Bill 1197, an extensive revision of the Workers' Compensation Law. See 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, we analyze this matter under the 1990 amendments.

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 work or modified employment;
>
> "(b) the attending physician gives the worker a written release to return to regular employment; or
>
> "(c) the attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment."

In this case, claimant was released, and in fact returned, to regular work on March 20, 1990. The employer was authorized to terminate payment of temporary total disability under amended ORS 656.268(3)(a).

The question here, however, is whether the employer was obligated to recommence payment of temporary total disability benefits on March 26, 1990, the date of claimant's termination. The employer contends that it was under no obligation to recommence payments of time loss because the March 20, 1990 release had not been rescinded and claimant was terminated for reasons unrelated to his compensable injury. We disagree.

Whether a claimant is entitled to temporary total disability benefits depends on whether a preponderance of the evidence indicates that he was disabled during the time period in question due to the compensable injury. Botefur v. City of Croswell, 84 Or App 627 (1987); Kathy K. Mason, 43 Van Natta 1342 (1991). A doctor's verification of an inability to work (or of an ability to work for that matter) is certainly evidence relevant to the question, but it is not necessarily the only relevant evidence. The entire record is relevant to the question of whether claimant was entitled to additional temporary total disability. Id. at 630-631. See Alice A. Taug, 43 Van Natta 2609 (1991) (despite her doctor's authorization of time loss, claimant's return to regular work for a whole month preponderates in favor of the conclusion that she did not leave work because of the compensable injury).

Here, the Referee found (in WCB Case No 90-16778) that claimant suffered a compensable low back strain injury on March 19, 1990, when he lifted weights exceeding the 20 pound lifting limitation imposed by his treating physician. He returned to his doctor after work that same evening because he was still in pain. The next morning when he reported to work, he was made to understand that unless he went back to his doctor and got a full duty release, he would be terminated. He immediately returned to his doctor, who gave claimant a full duty release so that claimant would not lose his job. Thus, the record establishes that the release was given for other than a medical purpose. Accordingly, we do not consider the release persuasive evidence that claimant was able to perform his regular duties. In fact, because it was procured under a real threat of termination, the release was understandably characterized by Referee Lipton as a "sham." In any event, five days later, claimant was fired (for allegedly being "too slow," and for talking too much). Under these circumstances, we find claimant's

testimony credible that he was unable to perform his regular duties and was terminated for that reason.[1]

Because claimant was terminated for reasons related to his injury, he was entitled to the resumption on March 26, 1990 of temporary total disability benefits and to the continuation of such payments until the termination of payments was authorized by law. Accordingly, the employer will be ordered to pay claimant temporary total disability benefits for the period from March 26, 1990 to November 1, 1990.

Penalties

At hearing, claimant sought a penalty only for time loss benefits allegedly due and not paid by the employer for the period January 21, 1991 through June 10, 1991 (tr. 4). The Referee's order granted claimant's request, stating that although "claimant is entitled to temporary disability benefits from March 26, 1990 ***since penalties were only sought for the period from January 21, 1991 to June 10, 1991, a penalty will only be authorized for temporary disability benefits due for that period of time." We reverse.

During the subject time period, claimant's treating physicians were Drs. Takacs and Goldberg. Dr. Takacs authorized time loss from November 1, 1990 to January 21, 1991. Dr. Goldberg authorized time loss for 60 days from June 11, 1991. It is undisputed that the employer paid claimant time loss benefits for these two periods. However, neither physician authorized time loss for the period at issue here. Consequently, there were no amounts "then due" upon which to base a penalty under ORS 656.262(10), and since time loss was not authorized by the treating physicians, the employer's failure to pay time loss was reasonable. Therefore, the Referee's order will be reversed as it pertains to penalties for allegedly unreasonable claims processing.

Because 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 fee for claimant's counsel's services on review concerning the temporary disability issue is $1,250, to be paid by the employer. In reaching this conclusion, we have considered the time devoted to the issue (as reflected by claimant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated September 24, 1991 is affirmed in part and reversed in part. That portion of the order which assessed a penalty for allegedly unreasonable claims processing by the employer is reversed. The remainder of the Referee's order is affirmed. For services on review concerning the temporary disability compensation issue, claimant's counsel is awarded an assessed attorney fee of $1,250, to be paid by the employer.

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[1] The only evidence offered by the employer on the question of whether claimant was terminated for reasons unrelated to his compensable injury was a March 26, 1990 "personnel data form" which stated, in toto:

> "Mike is far too slow in pulling and packing orders. This is not effecte [sic]. He also spends too much time talking with other employees. This stops everyone from working." (Ex. 13C).

We do not find this document's bare assertion persuasive evidence on the point. Indeed, it is a far cry from the kind of evidentiary showing one would expect from an employer seeking to establish that the worker was discharged for "cause." Parenthetically, we note that the assertion that claimant was "too slow" is actually consistent with and supportive of claimant's testimony about the disabling effects of his injury.

In the Matter of the Compensation of
JOANN FRYMAN, Claimant
WCB Case Nos. 88-05650, 88-10557 & 88-10556
ORDER OF ABATEMENT
Karen M. Werner, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Claimant requests reconsideration of our June 9, 1992 Order on Remand which republished our September 26, 1990 order that set aside the insurer's denial of claimant's occupational disease claim for her low back condition. Submitting an affidavit concerning her counsel's services before the Court of Appeals, claimant seeks an attorney fee for her counsel's efforts pursuant to ORS 656.388(1).

We withdraw our June 9, 1992 order for reconsideration. Before taking this matter under advisement, the insurer is granted an opportunity to respond. To be considered, the insurer's response must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
DEBORAH K. ATCHLEY, Claimant
WCB Case No. 91-05626
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee McWilliams' order which: (1) declined to award claimant's counsel an assessed attorney fee under ORS 656.386(1) for his efforts in obtaining rescission of a "de facto" denial of medical services before hearing; and (2) declined to assess a penalty-related attorney fee under ORS 656.382(1) for the SAIF Corporation's allegedly unreasonable failure to timely reimburse claimant for medical expenses. On review, the issues are penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

In lieu of the Referee's first finding of fact, we make the following findings. SAIF paid prescription and mileage expenses in the amount of $88.23 on July 23, 1991, prior to the August 1, 1991 hearing. (Ex. 4). The parties stipulated that this payment was "more than 30 days late." (Tr. at 3).

We add the following findings.

Claimant's hearing request dated May 7, 1991 raised the issue of a "de facto" denial of medical services under ORS 656.245, in addition to penalty and attorney fee issues regarding the failure to reimburse prescription and mileage expenses.

Claimant's counsel, through his efforts in corresponding with the carrier and requesting a hearing, was instrumental in obtaining compensation for his client without benefit of a hearing.

FINDINGS OF ULTIMATE FACT

We adopt the Referee's first finding of ultimate fact, and add the following findings.

Claimant is not entitled to an assessed attorney fee under ORS 656.382.

Claimant is entitled to an assessed attorney fee under ORS 656.386(1).

CONCLUSIONS OF LAW AND OPINION

Penalty-Related Attorney Fee Under ORS 656.382(1)

The Referee declined to assess a penalty-related attorney fee under ORS 656.382(1), in addition to the penalty she assessed under ORS 656.262(10) for SAIF's late payment of prescription and mileage expenses. The Referee reasoned that our decision in Nicolasa Martinez, 43 Van Natta 1638 (1991) precludes assessment of a separate, penalty-related attorney fee, since the identical facts form the basis for penalties under both statutes. We agree and affirm the Referee's decision on this issue.

Attorney Fee Under ORS 656.386(1)

The Referee found that claimant's counsel was instrumental in obtaining compensation for his client without benefit of a hearing, through his efforts in corresponding with SAIF and requesting a hearing. However, the Referee declined to award a separate attorney fee under ORS 656.386(1), reasoning that it would contravene the legislative intent expressed in ORS 656.262(10) to simultaneously assess an attorney fee under a separate statute. We disagree.

Claimant contends that SAIF's late payment of prescription and mileage expenses constituted a "de facto" denial of compensation, which entitles her to attorney fees under ORS 656.386(1) for her counsel's efforts in setting aside the denial and obtaining compensation without benefit of a hearing. We agree with claimant's position.

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, the parties stipulated at hearing that payment was made "more than 30 days late." We understand the parties to mean that payment occurred more than 30 days after the statutory period expired within which SAIF must accept or deny a claim under ORS 656.262(6). Therefore, we conclude that the claim was denied "de facto" until the time when SAIF rescinded its denial before the hearing, and paid the claim.

Furthermore, we find, after our review of the record, that claimant's attorney was instrumental in obtaining compensation without benefit of a hearing, through his efforts in corresponding with SAIF and requesting a hearing. Accordingly, we conclude that claimant's attorney is entitled to an assessed attorney fee under ORS 656.386(1).

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 and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services prior to hearing concerning the "de facto" denial of medical services is $750, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue, as represented by claimant's counsel's statement of services, and the value of the interest involved.

We note that claimant's hearing request filed May 7, 1991, was apparently premature with respect to the issue of a "de facto" denial of medical services, in light of claimant's counsel's statement at hearing that the "reimbursement request was given to the SAIF Corporation sometime in March of 1991." (Tr. at 2-3). We have previously held that since a premature hearing request is ineffective and void, ORS 656.386(1) has no application because there was no denial to withdraw after the hearing request and before the hearing. See Michael A. Dipolito, 44 Van Natta 981 (1992), citing 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).

However, the present case is distinguishable from Dipolito. In Dipolito, no denial ever issued, whether written or "de facto," since a carrier had authorized the requested surgery before the expiration of the statutory period for accepting or denying a claim. Here, SAIF stipulated at hearing that its

payment was more than 30 days late, thereby admitting that it had eventually "de facto" denied the claim. Thus, even if claimant's hearing request on the "de facto" denial issue was premature, that infirmity was effectively cured at hearing by the parties' stipulation. See OAR 438-06-031 (new issues may be raised during the hearing, if supported by the evidence).

ORDER

The Referee's order dated August 30, 1991, as reconsidered October 4, 1991, is affirmed in part and reversed in part. That portion of the Referee's order that declined to award an assessed attorney fee for services concerning the SAIF Corporation's rescission of its denial prior to hearing is reversed. For services rendered in conjunction with the rescission of the denial, claimant's counsel is awarded an assessed attorney fee of $750, payable by SAIF. The remainder of the Referee's order is affirmed.

July 8, 1992 Cite as 44 Van Natta 1437 (1992)

In the Matter of the Compensation of
ALBERT M. BRUMMETT, Claimant
WCB Case No. 91-00845
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Hooton and Brazeau.

Claimant requests review of Referee Gruber's order that upheld the SAIF Corporation's denials of his aggravation claim for a low back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the "FINDINGS OF FACT" section of the Referee's order.

CONCLUSIONS OF LAW AND OPINION

In order to establish a compensable aggravation, claimant must prove that his compensable condition has worsened since the last award of compensation. See ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. See 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). The worsened condition must be established by medical evidence supported by objective findings. ORS 656.273(1). Additionally, because claimant has been awarded permanent disability for the compensable condition, he must also prove that the worsening is more than any waxing and waning of symptoms that were contemplated by the previous award. See ORS 656.273(8).

The Referee concluded that claimant had not established a compensable aggravation because: (1) there were no objective medical findings to support a worsening; and (2) the worsening did not exceed the waxing and waning of symptoms already contemplated by the prior award. We disagree.

Claimant's last award of compensation was the February 14, 1990 Opinion and Order, which awarded 10.5 percent unscheduled permanent disability, giving claimant a total unscheduled permanent disability award of 48 percent for the low back injury. (Ex. 25). At the time of the January 1990 hearing which gave rise to the February 14 order, claimant was experiencing pain in the low back and left leg, worsening with activity. On a scale of one through ten (with ten being most severe), claimant stated that he generally had pain in the four to five level, though it fluctuated on good and bad days. (Ex. 25-2, 25-3).

Claimant testified that his low back and left leg pain worsened in September or October 1990. (Tr. 11-12). Again using the one-to-ten scale, claimant stated his pain in late 1990 was generally in the seven to eight level. (Tr. 13). Claimant was released for light work as an oyster shucker, which he

commenced on December 5, 1990. (Exs. 41, 42). On December 11, 1990, Dr. Jany noted that claimant had some low back pain, but that an MRI scan revealed no disc herniation or spinal stenosis. (Ex. 42A). In January 1991, Dr. Thompson, examining physician, diagnosed chronic low back pain secondary to back surgery which claimant underwent in January 1988 due to the compensable injury. (Ex. 46). In March 1991, Dr. Jany released claimant from work for two weeks due to low back and left leg symptoms. (Ex. 42B; Tr. 15-16).

In May 1991, after returning from active military duty abroad, Dr. Bert resumed claimant's care. By a concurrence letter, Dr. Bert opined that claimant's back condition had worsened and that the worsening was due in major part to the compensable back condition. Dr. Bert added that the increased symptoms were more than waxing and waning of symptoms and were likely the result of nerve irritation caused by swelling or scar tissue. (Ex. 48-2).

Based on this record, particularly claimant's testimony and Dr. Bert's opinion, we find that claimant's low back condition has worsened since the February 14, 1990 award of compensation, rendering him less able to work. See Smith v. SAIF, supra; Edward D. Lucas, supra. Additionally, we find that the compensable injury was a material contributing cause of the worsened condition. See Grable v. Weyerhaeuser Company, 291 Or 387, 400-01 (1981).

We also find that the worsened condition is established by medical evidence supported by objective findings. We have interpreted "objective findings" to include any physically verifiable impairment or a physician's determination, based on examination of the claimant, that the claimant has, in fact, a disability or need for medical services. Suzanne Robertson, 43 Van Natta 1505 (1991). Here, Dr. Bert determined, based on his examination of claimant, that claimant had increased low back symptoms due to nerve irritation caused by swelling or scar tissue. That is sufficient. Contrary to the Referee's implied reasoning, a physician's determination need not be established by diagnostic evidence of a pathological change in claimant's condition.

Finally, we do not find that the February 14, 1990 award of compensation contemplated future waxing and waning of low back symptoms. The Referee found that significant waxing and waning of symptoms were contemplated, based on claimant's condition at the time of the January 1990 hearing. However, neither the February 14 Opinion and Order nor the medical evidence predating that order mentions that claimant will suffer future symptomatic exacerbations or waxing and waning of symptoms. Absent such evidence, there is no basis for finding that waxing and waning of symptoms were contemplated. See, e.g., Pauline E. Bingham, 43 Van Natta 1817, 1818-19 (1991). Accordingly, we conclude that claimant has established a compensable aggravation.

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 $2,500, 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 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 September 13, 1991 is reversed. The SAIF Corporation's aggravation denials are set aside, and the claim is remanded to SAIF for processing according to law. For services at hearing and on review concerning the aggravation issue, claimant is awarded an assessed attorney fee of $2,500, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
STEVEN D. FRY, Claimant
WCB Case No. 91-05551
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

The self-insured employer requests review of that portion of Referee Baker's order that set aside its denial of claimant's medical services claim for right knee surgery. On review, the issue is medical services. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the proposed arthroscopy is a compensable medical service, because claimant's industrial injury is the major contributing cause of his current need for treatment for his resultant disability. We agree.

At the outset, we note that the employer denied payment for the requested surgery on the grounds that claimant's need for the treatment was not sufficiently related to his industrial injury. Thus, because this dispute concerns the question whether the need for the medical service is causally related to the compensable injury, it is a "matter concerning a claim" subject to the initial jurisdiction of our Hearings Division. ORS 656.704(3); Michael A. Jaquay, 44 Van Natta 173 (1992).

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, such as the proposed arthroscopy, is compensable if the need for the service is related to the compensable injury. Brooks v. D & R Timber, 55 Or App 688 (1982); Priscilla J. Bosley, 43 Van Natta 380 (1991). Because the medical evidence establishes that claimant's current right knee condition was caused by a combination of a preexisting condition and the compensable injury, claimant must establish that the compensable injury is the major contributing cause of his need for medical treatment. Bahman M. Nazari, 43 Van Natta 2368 (1991); Thomas Porter, 43 Van Natta 2599 (1991).

The parties presented expert opinions on causation from three orthopedic surgeons. Claimant relies on the opinion of Dr. Jones, who has treated claimant since December 1990 and proposed the arthroscopy. Given claimant's persistent knee problems since 1985, he opined that claimant's need for treatment directly arose from the compensable injury. The employer relies on the opinions of Dr. Thompson and Dr. Woolpert. Thompson examined claimant in March 1991 and opined that claimant's need for the proposed surgery was not related to the compensable injury, but rather to an underlying condition that preexisted the injury and that had been subsequently aggravated by three incidents occurring after 1985. Woolpert did not examine claimant but, after a review of the medical file, opined that the compensable injury merely produced an episodic aggravation of claimant's preexisting chondromalacia that had long since resolved. He concluded that events occurring after the compensable injury were the major contributing cause of claimant's need for treatment.

After our review, we find Jones' opinion to be the most persuasive of that offered by the three physicians and find it sufficient to support a finding that claimant's compensable injury is the major contributing cause of his current need for treatment. McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). We are unpersuaded by contrary opinions of Thompson and Woolpert, who base their opinions on the conclusion that claimant's condition was not causally related to the 1985 compensable injury even as it existed at the time of his second knee surgery in 1987. As noted by the Referee, that conclusion conflicts with a prior Referee's December 1988 determination that claimant's condition at that

time was causally related the 1985 injury. Because both opinions are based on legally impermissible conclusions, we give them little weight. See Kuhn v. SAIF, 73 Or App 768 (1985).

In short, we find that the medical evidence is sufficient to establish that claimant's compensable injury is the major contributing cause of his current need for treatment. Accordingly, we agree with the Referee that the proposed arthroscopy is a compensable medical service and that the employer's denial of payment must be set aside.

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 medical services issue is $1,250, 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 August 30, 1991 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,250, to be paid by the self-insured employer.

In the Matter of the Compensation of
LARRY W. GANGE, Claimant
WCB Case Nos. 90-21432 & 90-15533
ORDER ON REVIEW (REMANDING)
Quintin B. Estell, Claimant Attorney
David Ray Fowler (Saif), Defense Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

EBI Companies, on behalf of Lou Surcamp Logging, requests review of those portions of Referee Baker's order that: (1) set aside its partial denial of claimant's claim for a current low back condition; and (2) upheld the SAIF Corporation's denial, on behalf of Polk Community Living, of claimant's "new injury" claim for the same condition. Claimant cross-requests review, contending that SAIF is responsible for his current low back condition if EBI is not. In his brief, claimant argues that his permanent disability award should be increased if SAIF is responsible. On review, the issues are responsibility and, if SAIF is responsible, extent of unscheduled permanent disability. We reverse in part, modify in part, and remand in part.

FINDINGS OF FACT

Claimant has a history of low back problems dating to a 1982 injury and an accepted claim with EBI. Since then, claimant has had two lumbar laminectomies, the latter performed by Dr. Lewis in 1988.

In early March 1990, claimant began working for SAIF's insured, at a residence for developmentally disabled persons. On May 11, 1990, he lifted a fallen resident and reported the incident to the employer. Claimant did not formally claim to have injured himself at that time. About an hour later, claimant began experiencing low back and right leg symptoms, which did not resolve.

On May 14, 1990, claimant sought treatment from Dr. Lewis for his back. Lewis recorded claimant's history of a May 11, 1990 lifting incident and the onset of low back and right leg pain. (Ex. 210). Claimant's symptoms worsened progressively thereafter. He continued to seek treatment from Dr. Lewis and at a Veteran's Hospital. In August 1990, Dr. Lewis recommended surgery.

SAIF denied both compensability and responsibility for claimant's low back condition. EBI denied responsibility only.

ULTIMATE FINDINGS OF FACT

A May 11, 1990 lifting incident during claimant's employment with SAIF's insured was a material contributing cause of claimant's subsequent disability and need for treatment for his low back condition.

The occurrence of claimant's May 11, 1990 injury is established by medical evidence supported by objective findings.

CONCLUSIONS OF LAW AND OPINION

Claimant has a compensable low back condition, stemming from a 1982 injury which EBI accepted. The Referee determined that responsibility for claimant's current low back condition does not shift from EBI to SAIF in this case, based on his determination that claimant did not suffer a new injury while working for SAIF's insured. 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."

The Referee stated that, in order to establish a new injury, under the statute, EBI must prove that a work injury with SAIF's insured was the major cause of claimant's subsequent disability or need for medical treatment. However, subsequent to the Referee's order, we have interpreted ORS 656.308(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 an injury involving the same condition during the later employment was a material contributing cause of the subsequent disability or need for medical treatment. Ricardo Vasquez, 43 Van Natta 1678 (1991); Mark N. Wiedle, 43 Van Natta 855 (1991); see Rosalie S. Drews, 44 Van Natta 36 (1992).

Thus, in order to escape continuing responsibility for claimant's low back condition, EBI must prove that a new injury, during claimant's employment with SAIF's insured was a material contributing cause of his current low back disability or need for medical services.

The Referee concluded that EBI failed to prove major causation. In reaching this conclusion, he declined to rely on Dr. Lewis' opinion, stating that it is based on two assumptions which the Referee found to be insufficiently supported. According to the Referee, Dr. Lewis' opinion is not reliable because it depends on the existence of a new right lateral disc herniation (which claimant did not have) and an immediate onset of low back and right leg symptoms following a May 11, 1990 work incident. We disagree. Although Dr. Lewis did suspect a disc herniation due to claimant's symptoms, his opinion regarding causation is not based on that diagnosis. We further find that claimant did have an onset of symptoms with the May work incident. Finally, after our de novo review, we conclude that EBI has proven that claimant's May 1990 work incident was a material cause of his subsequent disability and need for treatment for his low back and, consequently that responsibility for that condition shifts to SAIF.

In reaching this conclusion, we note and defer to the Referee's demeanor-based positive credibility finding regarding claimant. Considering claimant's credible testimony regarding the May 11, 1990 lifting incident at work and his timely reporting of the event to the employer and Dr. Lewis, we find that the incident happened as claimant described it.

Regarding causation, we give greater weight to the opinion of Dr. Lewis, the treating physician, because we find no persuasive reason to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). We note that neither Dr. Lewis nor claimant attributed much importance to the May incident at the time. However, when claimant's symptoms persisted and worsened over the following months, Dr. Lewis began to suspect a disc problem, noting that the May lifting incident marked an onset of symptoms. (See Exs. 217, 218). Dr. Lewis once mistakenly stated that claimant's May 1990 symptoms were severe from their onset (Ex. 217). However, in view of the fact that claimant reported low back and right leg symptoms soon after the May incident and described the pain worsening progressively thereafter, we find that Dr. Lewis' August 1990 misstatement concerning claimant's May 1990 symptoms does not diminish the overall reliability of his opinion. In reaching this conclusion, we note that Dr. Lewis otherwise reported claimant's symptoms as claimant did. Furthermore, the progressive nature of claimant's symptoms is reflected by the reports of other examining physicians.

In October 1990, claimant sought treatment at a Veteran's Hospital. He reported "severe" low back pain and numbness and decreased use of his right leg. He also reported the May incident and a related "subacute onset" of symptoms. (Exs. 220A-3; 220A-11; 220B-1).

Claimant did not report the May 11 event at a May 23, 1990 independent medical examination. However, as we have noted, claimant's immediate symptoms, following the lifting incident, were not severe and he did not attribute particular significance to the incident until his symptoms became unrelenting later. Moreover, considering claimant's two prior back surgeries, we do not find it unreasonable for him to view an event that he walked away from as relatively insignificant.

SAIF relies on the opinion of Dr. Short, who examined claimant and reviewed his records. Short stated that, after the 1988 surgery, claimant "did fairly well. . .until May 11, 1990, when [he] had a minor on-the-job injury which resulted in a lower back sprain." (Ex. 224-1). He opined that "the leg symptoms resulting from the injury of May 1990 were due to the preexisting spinal stenosis which is pinching the nerve root" and concluded that the major contributing cause of claimant's need for surgery in December 1990 was his longstanding degenerative disc disease, not the "alleged minor incident" of May 1990. (Ex. 224-2) (Emphasis added). Considering Short's apparent acknowledgment that claimant suffered a back sprain in May 1990 and that the sprain caused symptoms, we conclude that his opinion supports our finding that claimant suffered a new injury during his later employment.

Therefore, considering claimant's credible reporting, the progressive worsening of symptoms following the May 1990 work incident, and the medical evidence supporting a causal relationship between that incident and claimant's subsequent disability and need for treatment for his low back, we conclude that claimant suffered a new injury while working for SAIF's insured. We further conclude that the existence of claimant's new injury is established by medical evidence, supported by objective findings, i.e., Dr. Lewis' reports, describing claimant's symptoms and relating them to the May lifting incident. Consequently, responsibility shifts to SAIF.

Finally, inasmuch as we find that claimant sustained a new injury with SAIF's insured, we must determine the extent of his disability due to the 1982 injury with EBI's insured. See Larry K. Rose, 41 Van Natta 69, 72 (1989); Refugio Guzman, 39 Van Natta 808 (1987). Claimant's disability is rated as of the time just prior to the new injury. See id.

Claimant raised the extent of disability issue at hearing, and evidence concerning that issue was submitted to the Referee. However, in view of the Referee's responsibility decision, relevant facts concerning the extent issue were neither discussed nor analyzed. We consider such an analysis essential to the determination of the extent issue in this case, particularly under the standards for rating disability. Therefore, we find that this record is insufficiently developed on the extent of disability issue. Accordingly, we remand this matter to the Referee with instructions to determine the extent of claimant's unscheduled disability due to the 1982 injury, as it existed immediately before May 11, 1990, the date of the new injury. See ORS 656.295(5); Refugio Guzman, supra. To assist the Referee in making such a determination, the Referee shall have the discretion to conduct further proceedings in any manner he believes will achieve substantial justice.

Attorney Fees

In light of our responsibility determination, SAIF, rather than EBI, must pay the attorney fee awarded by the Referee for services at hearing.[1] Additionally, claimant is entitled to an assessed attorney fee for services on Board review. After considering the factors set forth in OAR 438-15-101(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the responsibility issue is $1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as evidenced by claimant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated July 29, 1991 is reversed in part, modified in part, and remanded in part. That portion of the order that set aside the July 16, 1990 Determination Order is reversed and the Determination Order is reinstated. Those portions of the order that set aside EBI Companies' denial and upheld the SAIF Corporation's denial are reversed. EBI's denial of responsibility is reinstated and upheld. SAIF's denial is set aside and the claim is remanded to it for further processing in accordance with law. That portion of the order which directed EBI to pay claimant's counsel's fee for his services at hearing is modified so that the fee is payable by SAIF. For services on Board review, claimant's attorney is awarded a reasonable assessed attorney fee of $1,000, to be paid by the SAIF Corporation. The extent of claimant's unscheduled permanent disability under the July 1990 Determination Order is remanded to the Referee for a determination of the extent of claimant's unscheduled disability due to the 1982 injury with EBI's insured, as it existed immediately before the May 11, 1990 new injury with SAIF's insured.

[1] The resolution of attorney fees for services at hearing may be inconsistent with John L. Law, 44 Van Natta 1091 (1992). That case has been abated and the outcome on reconsideration is uncertain. 44 Van Natta 1157 (1992). Because of the parties' interest in a speedy resolution of the present case, however, we have issued this opinion without awaiting reconsideration of Law.

July 8, 1992 Cite as 44 Van Natta 1443 (1992)

In the Matter of the Compensation of
WILLIAM GIBBONS, Claimant
WCB Case No. 91-06977
CORRECTED ORDER ON REVIEW
Francesconi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

It has come to our attention that our prior Order on Review, which was mailed on June 30, 1992, referred to a Determination Order award of 5 percent (7.5 degrees) scheduled permanent disability for claimant's right arm (elbow) condition. However, the actual award was 5 percent (9.6 degrees) scheduled permanent disability. In order to correct this matter, we withdraw our prior order. In its place, as supplemented herein, we adhere to and republish our prior 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
JERRY R. MILLER, Claimant
WCB Case No. 91-03345
ORDER DENYING MOTION TO DISMISS
Patrick K. Mackin, Claimant Attorney
Randolph B. Harris (Saif), Defense Attorney

Claimant has moved the Board for an order dismissing the SAIF Corporation's request for Board review "for the reasons that the request for Board review was not sent to all parties to the proceeding before the referee." We deny the motion.

FINDINGS OF FACT

Claimant requested a hearing concerning the SAIF Corporation's March 15, 1991 denial. This request was acknowledged as WCB Case No. 91-03345. Claimant subsequently requested a hearing regarding Liberty Northwest's September 3, 1991 denial. This request was designated as WCB Case No. 91-11612. The two hearing requests were consolidated for hearing.

Following the hearing during closing argument, the Referee notified the parties that he would be entering "a separate dismissal order on claimant's request for hearing on the Liberty claim, which is the 91-11612 case." Thereafter, on January 9, 1992, the Referee issued an Order of Dismissal, dismissing claimant's hearing request concerning Liberty Northwest's denial. WCB Case No. 91-11612.

On January 17, 1992, the Referee issued an Opinion and Order regarding claimant's hearing request from SAIF's denial. WCB Case No. 91-03345. Neither Liberty Northwest, its insured, nor its attorney were listed as parties receiving a copy of the Referee's order.

On January 31, 1992, the Board received SAIF's request for Board review of the Referee's January 17, 1992 order (WCB Case No. 91-03345). The request included a certificate of personal service by mail upon claimant, claimant's counsel, SAIF's insured, and the Workers' Compensation Board. See OAR 438-05-046(2)(b).

On February 4, 1992, the Board received claimant's cross-request for review of the Referee's January 17, 1992 order. The cross-request included a certificate of personal service by mail upon claimant, SAIF, and the Workers' Compensation Board. See OAR 438-05-046(2)(b).

On February 6, 1992, the Board mailed a computer-generated letter to all parties acknowledging the request. The acknowledgment, which erroneously referred to both WCB Case Numbers 91-03345 and 91-11612, was also mailed to Liberty Northwest, its insured, and its legal representative.

On February 11, 1992, the Board mailed a letter to all parties acknowledging claimant's cross-request for review. This acknowledgment also erroneously referred to both case numbers and was sent to Liberty Northwest and its representatives. On February 12, 1992, the Board mailed an amended acknowledgment, notifying the parties that only the Referee's order in WCB Case No. 91-03345 was on 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). 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).

Although a Referee's conclusions and opinions in consolidated cases may be separately stated, if the Referee's decisions are contained in one final order and that order is appealed, we retain jurisdiction to consider all matters contained therein. William E. Wood, 40 Van Natta 999 (1988). Nevertheless, if a party has been dismissed from a proceeding and its' dismissal as a party is not contained in the

appealed Referee's order, it is not considered a party for purposes of Board review. Chris A. Miner, 42 Van Natta 915 (1990); Rual E. Tigner, 40 Van Natta 1789 (1988).

Here, Liberty Northwest was initially a party to the consolidated hearing. However, Liberty Northwest was dismissed as a party pursuant to the Referee's separate January 9, 1992 dismissal order. Consequently, Liberty Northwest was not a party to the Referee's January 17, 1992 Opinion and Order. Inasmuch as Liberty Northwest was not a party to the appealed Referee's order, SAIF was not required to provide Liberty Northwest with a copy of its request for Board review.

Claimant cites Mosley v. Sacred Heart Hospital, 113 Or App 234 (May 27, 1992), in support of his position that SAIF's appeal was defective. We find Mosley distinguishable. In Mosley, the court affirmed a Board order that had dismissed the claimant's request for Board review because she failed to send copies of her request to all parties to the Referee's order as required by ORS 656.295(2). In doing so, the court disagreed with the claimant's contention that she only needed to serve notice on one of several carriers in the proceeding before the Referee because she was only appealing that carrier's denial of her claim. The court reasoned that 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 a Referee. Inasmuch as the claimant had requested Board review of the Referee's order and since not all of the parties to the proceeding before the Referee had received notice of the request, the court held that the Board did not err in dismissing her request for review.

Here, as in Mosley, several cases were consolidated for hearing before the Referee. However, unlike Mosley, the Referee did not include all of those cases within one order. Instead, the Referee dismissed claimant's hearing request concerning Liberty Northwest in a January 9, 1992 dismissal order and subsequently issued a separate January 17, 1992 Opinion and Order regarding claimant's hearing request from SAIF's denial. Because SAIF requested Board review of the Referee's Opinion and Order and since Liberty Northwest was not a party to that order, SAIF was not required to provide Liberty Northwest with a copy of SAIF's request for Board review.

Finally, assuming arguendo that Liberty Northwest was a party to the appealed January 17, 1992 order, it received actual notice of the request in a timely manner. Since the Board's February 6, 1992 acknowledgment letter was mailed to all parties 17 days after the Referee's January 17, 1992 order and since Liberty Northwest was included within that group receiving the Board's acknowledgment, we conclude that it is more probable than not that Liberty Northwest received actual notice of SAIF's request for review within the statutory 30-day period. See Denise M. Bowman, 40 Van Natta 363 (1988). Under such circumstances, we have jurisdiction to consider SAIF's request for review. Argonaut Insurance Co. v. King, supra; Denise M. Bowman, supra.

Accordingly, claimant's motion to dismiss is denied. Inasmuch as the briefing schedule has already been completed, this case shall return to the Board docket to await review.

IT IS SO ORDERED.

July 8, 1992 Cite as 44 Van Natta 1445 (1992)

In the Matter of the Compensation of
PAMELA J. PANEK, Claimant
WCB Case No. 91-01720
ORDER DENYING RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Roy Miller (Saif), Defense Attorney

Claimant requests reconsideration of our May 12, 1992 Order on Review which: (1) declined to consider claimant's "supplemental memorandum"; (2) held that the Hearings Division lacked original jurisdiction to consider disputes pertaining to psychological treatment and a swimming program; and (3) declined to assess an attorney fee pursuant to ORS 656.382(1) for unreasonable claim processing concerning a monthly "weigh-in" requirement. Claimant acknowledges that she has petitioned the

Court of Appeals for judicial review of our order. Nevertheless, relying on ORS 183.482(6), claimant notes that we retain jurisdiction to reconsider our decision.

As claimant accurately represents, at any time subsequent to the filing of a petition for judicial review and prior to the date set for hearing, we may withdraw an appealed order for purposes of reconsideration. ORS 183.482(6); ORAP 4.35; Glen D. Roles, 43 Van Natta 278 (1991). However, this authority is rarely exercised. Ronald D. Chaffee, 39 Van Natta 1135 (1987).

After review of claimant's arguments, we decline to reconsider our May 12, 1992 order. Nevertheless, we offer the following additional comments.

To begin, claimant challenges our rejection of her "supplemental memorandum." Retracing SAIF's claim processing conduct, the "supplemental memorandum" provided a further discussion of the case and additional reasoning in support of claimant's contention that the Referee's penalty and attorney fee assessments should be affirmed. The memorandum, which was received by the Board approximately one month after the expiration of the briefing schedule, did not refer to any recent Board or court holding.

Briefs or argument submitted after the expiration of the briefing schedule will not be considered on review. OAR 438-11-020(2). Yet, parties are not prohibited from bringing to the Board's attention recent decisions issued after completion of the briefing schedule. Betty L. Juneau, 38 Van Natta 553, 556 (1986). Subject to this exception, supplemental argument will not be considered. Id.

Here, claimant's supplemental memorandum was submitted after expiration of the briefing schedule and was not based on recent case decisions issued subsequent to the briefing schedule. Moreover, claimant has neither presented, nor have we found, extraordinary circumstances to justify the acceptance of this post-briefing schedule memorandum. See OAR 438-11-030. Under such circumstances, we continue to decline to consider claimant's supplemental memorandum.

Secondly, claimant continues to argue that the Hearings Division has original jurisdiction to consider her medical treatment disputes. In addition to her prior contentions concerning the jurisdictional issue, claimant asserts that the Medical Director has previously refused to resolve the dispute.

We adhere to our prior reasoning that original jurisdiction over these matters rests with the Director pursuant to ORS 656.327. Furthermore, even assuming that the Medical Director has declined to take affirmative action regarding the dispute, claimant's remedy would not rest with this forum. We have previously held that the Director's apparent refusal to comply with the review procedures of ORS 656.327 may be grounds for the issuance by a circuit court of a writ of mandamus compelling the Director to act, or to that same end, it may constitute a basis for circuit court review under ORS 183.484 and 183.490. See Jack H. Glubrecht, 43 Van Natta 1753 (1991).

Finally, claimant asserts that our refusal to award an attorney fee under ORS 656.382(1) despite our conclusion that SAIF's "monthly weigh-in" was unreasonable is inconsistent with several of our recent decisions. Claimant is mistaken. We agree with the Referee's conclusion that SAIF's conduct in requesting "monthly weigh-ins" was unreasonable. Nevertheless, since the record fails to establish that such conduct either denied or delayed claimant's compensation, we continue to conclude that SAIF's actions did not constitute an unreasonable resistance to the payment of compensation as required by ORS 656.382(1). Consequently, we adhere to our prior reasoning that claimant is not entitled to an attorney fee award for SAIF's conduct.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
CHERYL L. SCHAEFER, Claimant
WCB Case No. 91-07980
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Sandra Haynes, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee Michael Johnson's order that directed it to pay an attorney fee to claimant's counsel for work performed in setting aside its denial. The employer contests both entitlement to and amount of the fee. 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 employer timely accepted claimant's right carpal tunnel syndrome (CTS). The employer's "de facto" denial of claimant's left CTS was rescinded prior to hearing. The Referee found that claimant's attorney was entitled to an assessed fee for his efforts in obtaining the "de facto" denial rescission of the left CTS. The employer challenges the award of an assessed fee, asserting that claimant's attorney was not instrumental in obtaining compensation for his client, as required by ORS 656.386(1). Specifically, the employer argues that there was no unpaid compensation prior to its rescission of the "de facto" denial of the left CTS condition because medical expenses relating to the left CTS condition and all time loss had been paid under the accepted right CTS condition. We disagree.

Payment of the medical expenses relating to the left CTS prior to the employer's acceptance of that claim did not create an acceptance of that claim or a duty to continue paying those left CTS medical expenses. ORS 656.262(9). The employer's duty to pay compensation relating to the left CTS was not established until it rescinded its "de facto" denial and accepted that condition.

"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). Thus, as a result of claimant's attorney's efforts in securing the employer's acceptance of the claim, claimant became entitled to all benefits set forth in ORS Chapter 656 resulting from the left CTS claim. Inasmuch as claimant's right to such benefits was not confirmed until the employer's acceptance, we hold that claimant's attorney was instrumental in obtaining compensation for claimant without a hearing. See Euzella Smith, 44 Van Natta 778 (1992); Fidel D. Chavez, 43 Van Natta 2515 (1991).

The employer further asserts that the $1,300 fee awarded by the Referee was excessive, given the minimal benefits secured for claimant. The employer also notes that the Referee referred to the fact that claimant's attorney participated in the hearing. We agree that the hearing was limited to the issue of penalties and attorney fees. Thus, claimant's attorney's participation in the hearing does not effect the assessed attorney fee relating to the prehearing denial rescission.

For purposes of determining a reasonable assessed attorney fee, we consider all of the factors set forth in OAR 438-15-101(4). We disagree with the employer that the acceptance of the left CTS claim provides minimal benefits to claimant. 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 in obtaining the pre-hearing denial rescission is $1,300, to be paid by the self-insured 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. Melva J. Gregory, 44 Van Natta 1009 (1992). Kimberly Wayne, 44 Van Natta 328 (1992).

ORDER

The Referee's order dated October 22, 1991 is affirmed.

In the Matter of the Compensation of
DANIEL J. TINGLEY, Claimant
WCB Case No. 90-06835
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roderick Peters (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Hoguet's order that: (1) awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the left leg, whereas a Determination Order had awarded no permanent disability; and (2) increased claimant's unscheduled permanent disability award for his left hip condition from 45 percent (144 degrees), as awarded by a Determination Order, to 49 percent (156.8 degrees). On review, the issue is extent of permanent disability, unscheduled and scheduled. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

ULTIMATE FINDINGS OF FACT

We adopt the Referee's first, second and fourth findings. In lieu of the Referee's third and fifth findings, we make the following ultimate findings of fact.

Claimant's highest SVP over the 10 years preceding the date of hearing is 2 as a groundskeeper, for a rating of +4.

Claimant's loss of earning capacity equals 74 percent unscheduled PPD.

CONCLUSIONS OF LAW AND OPINION

In evaluating the extent of claimant's permanent disability, the Referee applied the disability standards in effect at the time of the most recent Determination Order of November 21, 1990. Claimant's sole argument on review is that the Referee erred in applying the standards as amended by the Director's temporary rules because the Director failed to comply with the statutory requirements for promulgating temporary rules as set forth in ORS 183.335(5). Raising an argument that he did not assert at hearing, claimant contends that the temporary rules amending the disability standards are invalid.

We agree with claimant that he should be rated under the disability standards that became effective on January 1, 1989, without regard to the subsequently adopted temporary rules. However, we do so for the following reasons.

The Referee applied the disability standards effective January 1, 1989, as amended by temporary rules contained in WCD Admin. Order 15-1990, effective October 1, 1990, and WCD Admin. Order 20-1990, effective November 20, 1990, because claimant's last Determination Order issued November 21, 1990. However, those standards also provide that they are applicable only to those claims where the claimant became medically stationary after July 1, 1990. Former OAR 436-35-003. For claims where the claimant became medically stationary before July 1, 1990, as in the instant case, the former standards, effective January 1, 1989, apply. WCD Admin. Order 6-1988.

We note, parenthetically, that the permanent standards adopted in March 1991 and effective April 1, 1991, clarify that for workers who became medically stationary prior to July 1, 1990, the disability standards contained in WCD Administrative Order 6-1988 shall be used in rating disability. OAR 436-35-003(1). In addition, OAR 438-10-010(1) provides that when a claimant becomes medically stationary on or before July 1, 1990, the disability standards set forth in WCD Administrative Order 6-1988 shall be applied at hearing and on review of the Determination Order. WCB Admin. Order 8-1991, effective November 7, 1991.

On review, claimant requests that we remand this case to the Referee to recalculate the extent of claimant's disability under the disability standards that became effective January 1, 1989, without regard to the subsequent, temporary rules. We may remand to the Referee only if we should find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Here, we find that the record is sufficiently developed to permit us to evaluate the extent of claimant's permanent disability under the appropriate standards. See Carl Smith, 44 Van Natta 1175 (1992). Accordingly, we deny claimant's request to remand and proceed with our evaluation.

Scheduled Permanent Disability

The Referee awarded claimant 5 percent scheduled permanent disability due to weakness or atrophy of the left thigh, based on the June 5, 1990 evaluation of Dr. Soot, claimant's treating orthopedist, who found that claimant has sustained 50 percent loss of strength of the left thigh. See former OAR 436-35-230(5); (Ex. 23-7). The Referee found insufficient evidence to award an additional 5 percent scheduled disability for a chronic condition limiting repetitive use of the left leg. See former OAR 436-35-010(7). We agree with the Referee's findings and conclusion on this issue, and affirm the scheduled permanent disability award.

Unscheduled Permanent Disability

We apply the standards set forth in former OAR 436-35-270 through 436-35-440 for rating unscheduled permanent disability. WCD Admin. Order 6-1988. The parties stipulated at hearing that claimant is entitled to a 29 percent impairment rating, a value of +1 for the age factor, and a value of zero for the formal education factor. We address only the disputed factors of skills, training-education, and adaptability. See former OAR 436-35-300(4), (5); 436-35-310.

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 "successfully performed" by a claimant during the ten years prior to the date of determination is used to determine a value for skills. For our purposes, under former OAR 436-35-300(4), the date of determination is the date of hearing. Larry L. McDougal, 42 Van Natta 1544 (1990). "Successful performance" is defined in OAR 436-35-300(4) as "remaining on the job the length of time necessary to meet the specific vocational preparation time requirement for that job."

Claimant's highest SVP during the ten years preceding the hearing is 2 as a groundskeeper (DOT # 406.687-010). Therefore, the appropriate value for skills is +4. Former OAR 436-35-300(4).

Training-Education

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

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

The "standards" do not define the term "specific vocational pursuit." Because we conclude that former OAR 436-35-300(5) was intended to differentiate between those who have and those who have not acquired formal or on-the-job training sufficient to perform something other than entry-level employment, we interpret "specific vocational pursuit" to mean employment other than an entry-level position. See Larry L. McDougal, supra at 1546.

Here, claimant has acquired on-the-job training as a groundskeeper, performing that job for 2-1/2 years, which we find is sufficient to perform that job in other than an entry-level capacity. Therefore, claimant has competence in some specific vocational pursuit, even though that vocation may no longer

be within his physical capabilities. See Jimmie L. Wilson, 42 Van Natta 2526, 2528 (1990). Claimant's training rating is therefore zero. Former OAR 436-35-300(5)(b).

Adaptability

The adaptability value for a worker who is not working as a result of his compensable injury is determined by the worker's residual physical capacity, without regard to that worker's physical capacity prior to the injury. Former OAR 436-35-310(4).

Here, claimant is not working as a result of his compensable condition and no offer of employment has been made. Claimant's physical capacity is in the sedentary category with restrictions on kneeling, squatting, forward bending, stair climbing, crawling, walking on uneven ground, and lifting. See Exs. 9, 9A-4, 11 and 13AA). Therefore, we find that the appropriate adaptability value is +9. Former OAR 436-35-310(4)(d).

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 of 1 is added to his education value of 4 (formal education - 0, skills - 4, training - 0), the sum is 5. When that value is multiplied by claimant's adaptability value of 9, the product is 45. When that value is added to claimant's impairment value of 29, the result is 74 percent unscheduled permanent partial disability. Former OAR 436-35-280.

Overpayment

We affirm and adopt the Referee's determination that SAIF is entitled to recoup its overpayment in the amount of $1,997.86 from claimant's present and future permanent disability awards.

ORDER

The Referee's order dated May 17, 1991 is affirmed in part and modified in part. In addition to the Referee's award and the Determination Order award, claimant is awarded 25 percent (80 degrees), giving him a total award to date of 74 percent (236.8 degrees) unscheduled permanent disability for his left hip condition. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, provided that the total attorney fees awarded by the Referee and Board orders shall not exceed $3,800. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
JOE E. CHAVARRIA, Claimant
WCB Case Nos. 90-19878 & 90-13028
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Marcia L. Barton (Saif), Defense Attorney
Garrett, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

Country Companies requests review of that portion of Referee Livesley's order that: (1) set aside its denial of claimant's aggravation claim for his current low back condition; (2) set aside its denial of claimant's consequential condition claim for his renal insufficiency condition; and (3) upheld the SAIF Corporation's denial of claimant's claim for the same conditions. Claimant cross-requests review of that portion of the Referee's order that assigned responsibility for his low back and renal insufficiency conditions to Country Companies. On review, the issue is responsibility. We reverse in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's work for his employer after January 1987, while SAIF was on the risk, caused or worsened his back and kidney conditions. However, the Referee concluded that, because claimant had not experienced an actual, independent compensable new injury with SAIF, Country Companies remained responsible for claimant's conditions. We disagree.

Subsequent to the Referee's order, we concluded that the phrase "new compensable injury" as used in ORS 656.308, also includes a new occupational disease. See Donald C. Moon, 43 Van Natta 2595 (1991) (Board cannot identify any policy reason to distinguish between an injury and an occupational disease for the purposes of shifting responsibility to a subsequent employer). Accordingly, in the present case, Country Companies, as the initially responsible insurer, remains responsible for claimant's continued or increased disability during his employment with a later carrier, unless claimant sustains a new injury or occupational disease during the subsequent coverage. See Ricardo Vasquez, 43 Van Natta 1678 (1991).

The evidence shows that claimant's condition did not result from a discrete incident or period of work activity after SAIF went on the risk. Thus, claimant did not sustain a new injury. Valtinson v. SAIF, 56 Or App 184 (1992). Accordingly, we review the record to determine whether claimant's work activity after July 1, 1987, is the major contributing cause of the worsening of his low back condition.

In May 1990, Dr. Woolpert, M.D., examined claimant and reported that his underlying problem all along had been degenerative disc and joint disease of the low back area. Dr. Woolpert reported that, based on claimant's description of increasing left leg pain dating back to July 1989, his work activity "most probably did contribute to his worsened back condition on or around that time." Dr. Woolpert concluded that claimant's work activity in Summer 1989 contributed to a "material worsening of his low back difficulty."

In October 1990, Dr. Hansen, claimant's treating physician, agreed with a letter from Country Companies' counsel stating that claimant's work in 1988 and later years materially worsened his back condition. Dr. Hansen also agreed that claimant's underlying back condition had worsened and was not merely a flare-up of symptoms.

Finally, Dr. Hacker, M.D., claimant's treating surgeon, believed that claimant's problem began in 1983 and "the clinical course beyond that is one of worsening." He expected that "repetitive motion about the back which seemed to have initiated (his) problem could have added to his present condition and need for treatment."

Under the circumstances, we conclude that claimant's work after July 1, 1987 is the major cause of the worsening of his low back condition. Accordingly, responsibility for claimant's low back condition and consequential kidney condition is shifted to SAIF.

On review, SAIF argues that claimant's low back pain has continued, unresolved, since the 1983 injury. SAIF contends that, pursuant to the provisions of ORS 656.005(7)(a)(B), where claimant has a preexisting condition, a new injury would be compensable only if it became the major cause of his disability or need for treatment. We disagree.

We have held that the continuing effects of an initial compensable injury do not amount to a preexisting condition for purposes of ORS 656.005(7)(a)(B). Rosalie S. Drews, 44 Van Natta 36 (1992). Accordingly, we reject SAIF's argument that it may avoid responsibility by establishing that claimant's 1983 injury continues to be the major cause of his disability or need for treatment.

We conclude that Country Companies has successfully shifted responsibility of claimant's low back condition and consequential renal insufficiency condition to SAIF. The Referee is, therefore, reversed on the issue of responsibility.

At hearing, the Referee awarded claimant's counsel an attorney fee of $4,900, payable by Country Companies. Inasmuch as we have determined that responsibility for the claim lies with SAIF, the Referee's order shall be modified to require payment of the attorney fee by SAIF, for claimant's counsel's services at hearing.

Moreover, we find that claimant is entitled to an attorney fee for services on review. Inasmuch as both insurers denied compensability and no .307 order issued, claimant's right to compensation was at risk at the hearing. Both compensability and responsibility were decided by the Referee. Therefore, by virtue of the Board's de novo review authority, compensability remained at risk on review as well. See Dilworth v. Weyerhaeuser Co., 95 Or App 85 (1989). Consequently, claimant's counsel is entitled to an assessed attorney fee for services on review. See Tanya L. Baker, 42 Van Natta 2818 (1990).

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 SAIF, the insurer responsible for the claim. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated August 20, 1991 is reversed in part and modified in part. That portion of the Referee's order that set aside Country Companies' denial of claimant's low back and kidney claim is reversed. Country Companies' denial is reinstated and upheld. The SAIF Corporation's denial of claimant's low back and kidney claim is set aside and the claims are remanded to SAIF for processing according to law. The Referee's attorney fee award of $4,900, payable by Country Companies is modified. In lieu of that award, SAIF is directed to pay claimant's counsel's attorney fee of $5,400 for services at hearing and on review.

In the Matter of the Compensation of
KENNETH M. WAGNER, Claimant
WCB Case No. 91-03498
ORDER OF ABATEMENT
Welch, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney

On June 11, 1992, we reversed a Referee's order that had set aside the insurer's denial of claimant's aggravation claim for a herniated disc. Claimant 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 June 11, 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
ROBERT I. FAST, Claimant
WCB Case Nos. 91-03855 & 88-18749
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Susan Ebner (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Kinsley.

The SAIF Corporation requests review of Referee Schultz' order that: (1) increased claimant's scheduled permanent disability award for a right hand condition from 25 percent (37.5 degrees), as awarded by Determination Order, to 37 percent (55.5 degrees); (2) increased claimant's unscheduled permanent disability award for a low back condition from 9 percent (28.8 degrees), as awarded by Determination Order, to 25 percent (80 degrees); and (3) directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree. On review, the issues are extent of permanent disability, scheduled and unscheduled, and rate of scheduled permanent disability. We modify in part and affirm in part.

FINDINGS OF FACT

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

We do not adopt the "Findings of Ultimate Fact" and we do not find that claimant suffered spinal nerve plexus injuries at the T7-12, T8-11 and T8-T12 nerves.

CONCLUSIONS OF LAW AND OPINION

November 24, 1986 injury: scheduled permanent disability, right hand

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

For the amputation of the nailbed of the right middle finger above the DIP joint, claimant is entitled to a rating of 40 percent of the finger. See former OAR 436-35-030(6); Exs. 89, 94. He is also entitled to a rating for loss of sensation in his middle finger. After considering the evidence generated by the attending physician and applying the standards, we find that the appropriate value for this rating is 19 percent of the middle finger. See former OAR 436-35-110(a); Exs. 94, 97. Claimant is also entitled to a rating of 50 percent for reflex sympathetic dystrophy (RSD) of the middle finger. See OAR 436-35-110(6); Exs. 14, 15, 16, 26, 47, 94, 97, Tr. 13. In addition, claimant is entitled to the following ratings for right middle finger ranges of motion. He retains: 80 degrees flexion in the MP joint of his right middle finger for a 6 percent rating; 85 degrees flexion of the PIP joint for a 9 percent rating; and 0 degrees flexion of the DIP joint for a 45 percent rating. These values are combined for a total rating of 89 percent of the middle finger. See former OAR 436-35-060(7).

Regarding the right index finger, claimant is entitled to a rating of 50 percent for reflex sympathetic dystrophy (RSD). He is also entitled to a 9 percent rating for 75 degrees retained flexion in the MP joint; a 3 percent rating for 95 degrees flexion of the PIP joint; and a 26 percent rating for 30 degrees flexion of the DIP joint. The range of motion values and the value for RSD are combined for a total of 68 percent for the index finger.

Regarding claimant's right ring finger, we find that he retains 85 degrees flexion in the MP joint for a 3 percent rating; 90 degrees flexion of the PIP joint for a 6 percent rating; and 30 degrees flexion of the DIP joint for a 26 percent rating. These values result in a combined total of 32 percent.

Regarding claimant's right little finger, we find that he retains 80 degrees flexion in the MP joint for a 6 percent rating; 95 degrees flexion of the PIP joint for a 3 percent rating; and 60 degrees flexion of the DIP joint for a 6 percent rating. These values result in a combined total of 15 percent.

Because claimant will receive a greater award if the total value for each finger is converted to a value for the loss of use of the hand, the values are converted. See former OAR 436-35-070(1). After conversion, claimant is entitled to the following values for loss of use or function of the right hand: 17 percent for his right index finger impairment; 18 percent for his right middle finger impairment; 3 percent for his right ring finger impairment; and 1 percent for his little finger impairment. These values are added for a total of 39 percent scheduled disability for the loss of use or function of the right hand. See former OAR 436-35-070(2).

The Referee awarded claimant an additional 22 percent scheduled permanent disability, giving him a total scheduled award of 37 percent scheduled permanent disability for his right hand condition. On review, claimant asks that the Referee's order be affirmed. Consequently, we do not increase the award.

Finally, we adopt the Referee's conclusion and opinion that claimant's increased award of scheduled permanent disability shall be paid at the rate of $305 per degree.

For prevailing against SAIF's request for review regarding the extent and rate of scheduled disability for the right hand, claimant is entitled to an assessed attorney fee on Board review. ORS 656.382(2). We note that claimant's counsel filed no respondent's brief on review, but instead, submitted a letter indicating that claimant relies on the Referee's analysis and Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991). We have previously held that such a letter is sufficient "legal representation" to qualify for an assessed attorney fee. Loren L. Harnar, 44 Van Natta 918 (1992).

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 on review concerning the extent and rate of scheduled disability issues is $200, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's response), the complexity of the issues, and the value of the interest involved.

November 4, 1987 Injury

Extent of unscheduled permanent disability, low back

The standards in effect at the time of the October 18, 1988 Determination Order, which closed claimant's low back injury claim, apply for purposes of rating claimant's permanent low back disability. Former OAR 436-35-003; see former OAR 438-10-010. Accordingly, the applicable standards are those contained in WCD Administrative Orders 3-1988 and 5-1988.

The Referee determined that claimant is entitled to two 5 percent ratings for chronic conditions limiting repetitive use of the low back and right leg; a 4 percent rating for 55 degrees retained lumbar flexion; and a 6 percent rating for injury to the spinal nerve plexus. Accordingly, the Referee increased claimant's unscheduled permanent disability award from 9 percent to 25 percent. We modify.

Neither the standards effective July 1, 1988 (WCD Order 3-1988) nor the temporary rules effective August 19, 1988 (WCD Order 5-1988) provide disability ratings for chronic conditions limiting repetitive use of unscheduled body parts. However, based on claimant's credible testimony, (see Tr. 16), and the medical evidence establishing the permanency of his injury-related pain, we conclude that claimant is entitled to a 5 percent impairment rating for disabling low back pain resulting from his injury. See former OAR 436-35-320(1)(a); Daniel M. Alire, 41 Van Natta 752 (1989).

Regarding claimant's injury-related loss of range of motion, we agree with the Referee's determination that Dr. McMorine's report provides the most persuasive measurement. (See Ex. 78). However, we conclude that under former OAR 436-35-360(6), claimant is entitled to a 3.5 percent, rather than a 4 percent, rating for his 55 degrees of retained lumbar flexion. See Barbara J. Glenzer, 42 Van Natta 1879, 1881 (1990) (Rate range of motion measurements proportionately when the physician's measurements fall between those listed in the standards).

The Referee assigned a 6 percent impairment rating for loss of strength due to spinal nerve plexus injury. See former OAR 436-35-350(4). We disagree.

The only evidence suggesting that claimant has nerve plexus injury affecting his back is Dr. Christensen's February 1989 report, which describes "dorsolumbar strength loss impairment due to localized spinal nerve plexus injury with resultant loss of strength." (See Ex. 89-9). However, the report does not explain how the L4-5 injury could have caused damage to the T7-T12, T8-L1, and T8-T12 nerve roots. Because the mechanism of such an injury is unexplained, by Dr. Christensen or anyone else, we find that claimant has not produced sufficient evidence of compensable T7-T12, T8-L1, and T8-T12 nerve root injuries to allow for an award under the standards.

The parties agreed at hearing that claimant is entitled to a 5 percent rating for his L4-5 surgery and a value of 2 for his age, education and adaptability factors.

Claimant's impairment values are 5 percent for surgery, 5 percent for disabling pain, and 3.5 percent for lost range of motion. These are combined for a total impairment value of 13.5 percent. When that value is added to claimant's age, education and adaptability value of 2, and the sum is rounded to the next whole number, the total is 16 percent unscheduled permanent disability. The Referee's award of 25 percent will be reduced accordingly.

Extent of scheduled permanent disability, right leg

For claimant's disabling right leg pain motor impingement due to the compensable L5 nerve root injury (see Exs. 85, 87), the Referee awarded 5 percent unscheduled disability.

However, inasmuch as the impairment limits the loss of use and function of the right leg, which is a scheduled body part, we find that claimant is entitled to 5 percent scheduled disability for that condition. See former OAR 436-35-230(8).

ORDER

The Referee's order dated August 14, 1991 is modified in part and affirmed in part. Claimant is awarded 5 percent (7.5 degrees) scheduled permanent disability for the loss of use or function of the right leg. In lieu of the Referee's award of an additional 16 percent (51.2 degrees) unscheduled permanent disability, and in addition to the Determination Order award of 9 percent (28.8 degrees) unscheduled permanent disability, claimant is awarded 7 percent (22.4 degrees) unscheduled permanent disability for the low back condition, giving him a total unscheduled permanent disability award of 16 percent (51.2 degrees). In lieu of the Referee's out-of-compensation attorney fee, claimant's attorney is awarded 25 percent of the permanent disability award granted by this order, not to exceed $2,800, to be paid directly to claimant's counsel. The remainder of the order is affirmed. For services on review concerning the extent and rate of scheduled permanent disability for the right hand, claimant is awarded an assessed attorney fee of $200, payable by the SAIF Corporation.

In the Matter of the Compensation of
DAVID E. KENNEDY, Claimant
Own Motion No. 92-0278M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

The SAIF Corporation requests the Board reconsider its June 15, 1992 Own Motion Order that denied the reopening of claimant's claim on the ground that we lacked own motion jurisdiction to consider the request for claim reopening and temporary disability benefits.

SAIF contends that the claim was in a non-disabling status for the years of 1985, 1986 and 1987. Therefore, the aggravation rights expired as of May 28, 1990.

As noted in our prior order, although claimant was apparently injured in 1985, his claim was not filed nor processed until 1988. SAIF accepted claimant's claim as a nondisabling injury on August 9, 1988. (Ex. 8). The Determination Order issued on November 22, 1989 shows that claimant's claim was

reopened for temporary disability benefits as of August 9, 1988. Thus, claimant's non-disabling claim became disabling within one year from the time the claim was accepted. Under this circumstance, claimant's five-year aggravation rights run from the date of the first closure of the claim. Darrell K. Falline, 42 Van Natta 919 (1990); Richard M. Egli, 41 Van Natta 149 (1989). Inasmuch as claimant's claim was not closed until November 22, 1989, his aggravation rights do not expire until after November 22, 1994.

Accordingly, our June 15, 1992, order is abated and withdrawn. As supplemented herein, we adhere to and republish our June 15, 1992, order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

In the Matter of the Compensation of
RICHARD J. BOOKER, Claimant
WCB Case No. C2-01344
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Francesconi & Associates, Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

On June 10, 1992, the Board acknowledged receipt of the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury.

On June 30, 1992, the Board received a motion from Ingrim Architecture, PC (Ingrim), an employer insured by the SAIF Corporation. Ingrim moves to have the claim disposition agreement set aside on the ground that it does not agree with SAIF's acceptance of claimant's injury claim. Ingrim further contends that the proposed agreement should be set aside due to "fraudulent testimony given by (claimant) in a deposition."

At the outset, we find that, as an employer, Ingrim is a "party" as defined by the statute, and, as such, it may request that the proposed claim disposition agreement be set aside. See e.g. ORS 656.005(20); Hamid R. Amini, 42 Van Natta 188 (1990). However, as the insurer for Ingrim, SAIF has assumed the obligation to process claimant's injury claim under the Workers' Compensation Law. See ORS 656.005(14); 656.419(1). Such obligations necessarily include the acceptance of the claim and the payment of benefits. ORS 656.262; OAR 436-60-140. Furthermore, we find that, by contracting with SAIF as its insurer, Ingrim has authorized SAIF to act on its behalf in disposing of injury claims by entering into settlements such as claim disposition agreements. See Daniel C. King, 42 Van Natta 1377 (1990)

In addition, we do not find that Ingrim's dissatisfaction with SAIF's actions constitute one of the three grounds upon which a claim disposition agreement may be set aside. See ORS 656.236(1)(a)-(c). We conclude that, with regard to the employer's implied contention that SAIF did not act in its best interests, Ingrim's remedy lies within its contractual relationship with SAIF, rather than attempting to have set aside an agreement which has already been entered into by the parties.

Finally, Ingrim contends that the proposed agreement should be set aside because claimant "is not truthful in his testimony and the facts of the case have not been fully investigated."

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

Here, Ingrim contends that claimant gave fraudulent testimony in a deposition within the past 30 days. However, Ingrim has not submitted any evidence of the alleged fraudulent testimony, nor has it explained how such testimony demonstrates that the proposed disagreement has been based upon a misrepresentation of material fact. Accordingly, we do not find that it has been established that claimant made representations that were false and were made with the intent to deceive or mislead.

This agreement is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. The Board does not find any statutory basis for disapproving the agreement. See ORS 656.236(1). Accordingly, this claim disposition agreement is approved. An attorney fee payable to claimant's attorney according to the terms of this agreement is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
KENNETH J. BAUER, Claimant
WCB Case No. 89-00068
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Black's order which: (1) upheld the insurer's denial of claimant's current neck and low back conditions; and (2) declined to assess a penalty for allegedly unreasonable delay in paying medical bills. On review, the issues are compensability of medical services and penalties. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following modification. In lieu of the Referee's statement in the fourth full paragraph on page 2 of the Opinion and Order, we make the following finding: The settlement states that $20,000 is allocated to "future medical" expenses, "to be utilized for Claimant's future costs associated with any future back surgery which the Claimant may be expected to undergo." (Ex. 83-1).

With respect to the Referee's Findings of Ultimate Fact, we adopt only the third finding, as the first two findings are unnecessary to our decision. In addition, we find that claimant's 1985 compensable neck and back conditions are not a material contributing cause of his current need for treatment.

CONCLUSIONS OF LAW AND OPINION

The Referee upheld the insurer's denial of the compensability of claimant's current condition, concluding that claimant had failed to meet the requirements of Miville v. SAIF, 76 Or App 603 (1985), where the claimant sustained out-of-state injuries subsequent to a compensable Oregon injury. The Referee held that claimant's out-of-state injuries independently and materially contributed to claimant's current condition, and that claimant was compensated for his compensable conditions by entering into a settlement agreement in the form of a Disputed Claim Settlement regarding his out-of-state claim. We agree with the Referee's conclusion, but we base our conclusion on the following reasoning.

Because a hearing convened in this case before July 1, 1990, we apply the law in effect prior to the 1990 amendments to the Workers' Compensation Law. See 1990 Or Laws ch. 2, section 54.

Where a claimant has suffered an on-the-job injury in another state for which he has claimed, but has not been awarded, compensation, and the medical evidence is that the original Oregon injury materially contributed to claimant's current disability or need for medical treatment, even though the

out-of-state injury contributed independently to the present disability, the Oregon employer remains responsible for the claimant's condition. Miville v. SAIF, supra, 76 Or App at 607. The first crucial question is whether claimant can establish that his compensable 1985 neck and back conditions are a material contributing cause of his current need for medical treatment. See Roberta F. Ruscheinsky, 42 Van Natta 1915, 1916 (1990), citing Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 697-98 (1987).

Claimant asserts that no one contends that the 1985 conditions did not materially contribute to claimant's present disability. Therefore, claimant concludes that the "insurer can only shift responsibility if it can prove that claimant has been 'awarded compensation' by a foreign jurisdiction." Appellant's Brief at 7. We disagree.

We find no evidence that the insurer concedes compensability of claimant's current condition. Indeed, the insurer's denial letter states that it will not continue workers' compensation benefits after July 25, 1988, because "your current condition relates to the subsequent automobile accident of July 25, 1988," which allegedly occurred in the course and scope of employment with a new employer. (Ex. 47-1). At hearing, claimant's attorney stated that claimant contests the denial and contended "that his Oregon industrial injury is still the main cause of his need for treatment, and continued to be so, even after the Iowa injury." (Tr. 2). The insurer's attorney agreed with claimant's counsel's statement of the issue. (Tr. 3).

It is claimant's burden to establish that his current condition is compensable. ORS 656.266. Accordingly, claimant must first affirmatively establish that his compensable 1985 conditions are a material contributing cause of his current condition and need for medical treatment.

Claimant sustained cervical and lumbosacral strains in 1985 when a 60-pound box of toilet paper fell on his head while he was unloading a truck. (Exs. 1-1, 2). The diagnosis was cervical strain and lumbar strain with possible radicular right leg pain (Ex. 4-3). A myelogram on May 6, 1986 revealed bilateral extradural defects at the C4-5 level, but no disc herniation or other abnormality in the lumbar region. (Ex. 8). In an independent examination on June 4, 1986 by the Orthopaedic Consultants, claimant's diagnosis was "[c]ervical and lumbar strain, superimposed on degenerative disc disease in the cervical region," and he was not yet medically stationary. (Ex. 10-7).

In 1986 claimant relocated to Iowa, where he sustained a back injury in September 1987, diagnosed as "acute thoracic and lumbar strain," when he fell through a porch floor. (Ex. 20). A CT scan on October 28, 1987 revealed disc bulging at the L4-5 and L5-S1 levels. (Ex. 23, see also Ex. 22-1). On July 25, 1988, claimant sustained a work injury in Iowa when he lost control and rolled his tractor/trailer rig. (Ex. 25). He sustained numerous injuries, including, among others, compression fracture of the thoracic spine, T11; left facet fracture at L4-5 (Exs. 31, 39-1), and left shoulder AC joint separation (Exs. 29, 40). In January 1990, Dr. Koontz performed anterior cervical diskectomy and fusion at C3-4 and C4-5 in an effort to alleviate claimant's "intractable pain." (Ex. 61-2).

Under these circumstances, we find that the issue of whether the claimant's condition or his medical treatment from July 25, 1988 forward is materially related to his compensable 1985 injury is of sufficient medical complexity that we cannot decide it without expert opinion. Uris v. Compensation Department, 247 Or 420, 424-26 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

The medical evidence establishes that since July 25, 1988, claimant has been treated by the following doctors: Dr. Elliott, osteopath; orthopedists Boulden, Johnson and Bashara; and neurosurgeon Koontz. Dr. Neff, osteopath, consulted with Dr. Johnson regarding claimant's shoulder injury; and Dr. Wirtz, orthopedist, evaluated claimant for extent of disability related to the July 25, 1988 accident.

Dr. Elliott, who treated claimant both before and after the July 25, 1988 accident after succeeding to his father's practice (see Ex. 14), stated in January 1989 that he was still treating him for the original, 1985 injury. (Ex. 45-2). Dr. Elliott opined that

> "[T]he truck accident of July 25, 1988 did not show medical evidence of damage to his low back although I do feel it aggravated his underlying low back problems. I feel

that he has had increased symptoms of his low back condition but I feel that the original injury was of 8/12/85." (Ex. 53).

However, the other doctors express a contrary view. Dr. Boulden, who also treated claimant both before and after the 1988 accident (see Ex. 22A), opined that the 1985 back injury is no longer a material contributing cause of claimant's current low back condition. (Ex. 55). He expressed his opinion by agreeing with the insurer's counsel's summary of their telephone conversation. Dr. Boulden agreed with the following explanation prepared by counsel:

> "[T]he September, 1987, injury aggravated Mr. Bauer's preexisting degenerative changes in his back. Further, you interpreted the October 28, 1987 CT scan of the lumbar spine to show some bulging of the L4-5, L5-S1 discs and not a herniated disc at L5-S1. The 1987 injury caused this pathological change (disc bulge) of his preexisting back condition." (Ex. 55).

Dr. Johnson, an orthopedist who practices in the same office as Dr. Boulden, treated claimant after the 1988 accident (see Ex. 22). He observed that claimant's degenerative disc changes at L4-5 and L5-S1 are "obviously pre-existing but he was functioning well with it up until his injury in July and now his pain has persisted and impaired his function." (Ex. 48). Dr. Johnson opined that claimant's preexisting disc degeneration "was intermittently symptomatic prior to the truck accident in July, 1988. The truck accident in July, 1988 aggravated the pre-existing condition." (Ex. 79). Dr. Koontz, who performed a cervical diskectomy and fusion in January 1990, also opined that claimant "certainly aggravated" his preexisting, degenerative condition. (Ex. 59-1).

Both Dr. Neff, osteopath, and Dr. Wirtz, orthopedist, evaluated claimant for the purpose of rating extent of disability. Dr. Neff noted that he did not know the extent of claimant's impairment due to his 1985 injury, and therefore he did not include that impairment in his rating. (Ex. 44-2). Dr. Wirtz observed that claimant's "neck disc degeneration was a pre-existing condition and has not been changed anatomically or functionally in relationship to the 7/25/88 injury." (Ex. 54-3).

We find that only Dr. Elliott and Dr. Boulden directly address the question of whether and to what extent the compensable 1985 conditions are a material contributing cause of claimant's current condition and need for medical treatment, and their opinions reach opposite conclusions. We find that none of the other medical opinions either directly express or permit an inference that claimant's compensable 1985 injury was a material contributing cause of his current disability or need for medical treatment.

As between Drs. Elliott and Boulden, we find Dr. Boulden's opinion to be more persuasive. While both doctors treated claimant, we note that Dr. Elliott's records indicate claimant was primarily seen for prescription refills and scheduled manipulation treatments. (Ex. 14; Tr. 7). Dr. Boulden's notes, on the other hand, indicate that he examined and treated claimant's low back condition. (See Exs. 22, 55). We find that Dr. Boulden provides an explanation for his opinion, albeit not in his own words, consistent with the x-ray evidence available at the time of his opinion. Dr. Elliott, on the other hand, apparently reviewed only his own and his father's chart notes before offering his opinion. Accordingly, we conclude, based on Dr. Boulden's opinion, that the 1985 compensable conditions were not a material contributing cause of claimant's disability or need for medical treatment after July 25, 1988.

Because we have concluded that claimant failed to establish that his compensable Oregon injury was a material contributing cause of his disability or need for medical treatment, we do not address the remaining requirements expressed in Miville v. SAIF, supra.

Penalties

The Referee found that the record did not establish when the insurer received the medical bills in question, so that it was impossible to determine whether the bills had been paid within 60 days of receipt. Furthermore, we cannot determine on this record the date on which the medical bills were mailed, since there is no presumption that a document is mailed when dated. SAIF v. Tull, 113 Or App

449 (1992). Therefore, we are unable to infer a date of receipt based on the date of mailing. Accordingly, we affirm the Referee's findings and conclusion on this issue.

ORDER

The Referee's order dated July 23, 1991 is affirmed.

In the Matter of the Compensation of
JEROME F. BISCHOFF, Claimant
WCB Case No. 91-07659
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Julie K. Bolt (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of Referee Livesley's order that awarded an attorney fee to claimant under ORS 656.386(1). On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

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

Claimant is a member of the Oregon State Bar specializing in workers' compensation law. He represented himself throughout the proceeding regarding his claim.

CONCLUSIONS OF LAW AND OPINION

SAIF contends that claimant, although a member of the Oregon State Bar, is not entitled to an attorney fee for services rendered in representing himself with regard to his groin injury claim. We agree.

The Referee awarded claimant an assessed attorney fee pursuant to ORS 656.386(1), which provides:

> "In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable 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. * * *."

Moreover, our rules define "attorney fees" as "payment for legal services performed by an attorney on behalf and at the request of a claimant." OAR 438-15-005(4). Furthermore, "[a]ttorney fees for an attorney representing a claimant shall be authorized only if an executed attorney retainer agreement has been filed with the referee or Board." OAR 438-15-010(1). Other rules also speak in terms of allowing a fee to "an attorney representing a claimant." E.g. OAR 438-15-010(2).

We find that the statute, as well as our rules, evidence an intent to award fees only when an agency relationship exists, i.e., when an attorney represents a claimant separate from himself or herself. Further, our conclusion is consistent with our holding that a claimant who appears pro se is not entitled to an attorney fee. See, e.g., Stanley W. Talley, 38 Van Natta 1553, 1554 (1986). Moreover, we conclude that sound policy considerations support our conclusion. Such policy considerations were addressed by the United States Supreme Court in Kay v. Ehrler, 111 S.Ct. 1435 (1991). The issue in

Ehrler was whether a pro se litigant, who was an attorney, was entitled to an attorney fee award for prevailing in a civil rights action. In reaching its decision that no fee could be awarded under the applicable statute, the Court reasoned:

> "Even a skilled lawyer who represents himself is at a disadvantage in contested litigation. Ethical considerations may make it appropriate for him to appear as a witness. [footnote omitted] He is deprived of the judgment of an independent third party in framing the theory of the case, evaluating alternative methods of presenting the evidence, cross-examining hostile witnesses, formulating legal arguments, and in making sure that reason, rather than emotion, dictates the proper tactical response to unforseen developments in the courtroom. The adage that 'a lawyer who represents himself has a fool for a client' is the product of years of experience by seasoned litigators.
>
> "A rule that authorizes awards of counsel fees to pro se litigants -- even if limited to those who are members of the bar -- would create a disincentive to employ counsel whenever such a plaintiff considered himself competent to litigate on his own behalf. The statutory policy of furthering the successful prosecution of meritorious claims is better served by a rule that creates an incentive to retain counsel in every such case." Kay v. Ehrler, 111 S.Ct. at 1435.

Although the policy considerations underlying a civil rights action clearly differ in some respects from those involved in a workers' compensation proceeding, we nevertheless conclude that the rationale expressed by the Court in Ehrler has substantial application here. Accordingly, we conclude that a pro se claimant, whether or not an attorney, is not entitled to an assessed attorney fee under ORS 656.386(1).

ORDER

The Referee's order dated October 9, 1991 is reversed in part and affirmed in part. That portion of the order awarding claimant an assessed fee of $1,650 is reversed. The remainder of the order is affirmed.

July 14, 1992 Cite as 44 Van Natta 1461 (1992)

In the Matter of the Compensation of
EVERETT J. COLLEY, Claimant
WCB Case No. 91-11212
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Holtan's order that dismissed his hearing request for lack of jurisdiction. Claimant contends that the Hearings Division has jurisdiction to consider whether the scheduled permanent disability benefits awarded by a Determination Order dated February 19, 1991 should be paid at the rate of $305 per degree and whether penalties and attorney fees should be assessed for the insurer's failure to do so. On review, the issue is jurisdiction.

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

Claimant argues that his hearing request does not raise an objection to a Determination Order within the meaning of ORS 656.268(5), and therefore, he 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 Determination Order. Contrary to claimant's assertion, an objection to a 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, claimant must first request reconsideration by DIF before filing a hearing request. Lorna D. Hilderbrand, 43 Van Natta 2721 (1991); see also, Charlene J. Erspamer, 44 Van Natta 1214 (1992).

Claimant also argues that the Hearings Division has jurisdiction because his request for hearing raised a "question concerning a claim," regarding which a hearing may be requested at any time pursuant to ORS 656.283(1). However, the statute is limited by the provisions of ORS 656.319, which was amended in 1990 to provide for hearing requests concerning objections to a "reconsideration order" under ORS 656.268, whereas previously it had provided for hearing on a "determination order or notice of closure." ORS 656.319(4). Therefore, we conclude that we have jurisdiction to consider only objections to a reconsideration order. Lorna Hilderbrand, supra at 2722. 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.

Finally, claimant argues that he should not be required to exhaust a futile administrative remedy. He contends that requesting reconsideration of the Determination Order would be futile because DIF continues to award scheduled permanent disability at the rate of $145 per degree. However, we have held that claimant must exhaust his administrative remedies as prescribed in ORS 656.268(5), by first requesting reconsideration of a determination order to which he objects. Diane B. Allen, 44 Van Natta 1210 (1992). Inasmuch as the issues raised by claimant arise from the Determination Order, and he did not first request reconsideration of the Determination Order, the Referee properly dismissed his hearing request.

ORDER

The Referee's order dated November 7, 1991 is affirmed.

In the Matter of the Compensation of
RICHARD A. GARNER, JR., Claimant
WCB Case No. 91-00773
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Garaventa'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" except the second sentence and the last sentence of the first paragraph, which are replace with the following two sentences.

At sometime in or around June 1990, claimant felt some minor back pain while engaged in regular lifting activities at work.

Approximately one week later, he experienced numbness in his right leg.

CONCLUSIONS OF LAW

We adopt the reasoning and conclusions of the Referee with the following supplementation.

The Referee concluded that claimant's testimony was not alone sufficient to establish a material causal relationship between claimant's low back herniated disc condition and an incident at work

because the question of causation was a complex medical question which required medical evidence. We agree.

By his own account of the "incident," claimant experienced "just a little bit of back pain" while engaged in lifting work on some day that he could not recall particularly, in or around June 1990. (Tr. 11; 18). He continued working from 8 to 14 hours a day. He did not seek medical treatment until July 8, 1990 (approximately one week later, he testified), when he felt numbness in his right leg.

Claimant contends that his description of the lifting "incident" (including his symptoms following the incident) was consistent with Dr. Tsai's diagnosis of right L5 radicular compression due to "traumatic herniation." That may very well be the case. Like the Referee, however, we are unable to make such a finding without medical evidence on the point. There is no medical evidence in the record which directly addresses the question of causation presented here. The Referee left the record open for receipt of a supplemental report from Dr. Tsai. No supplemental medical report was submitted by claimant.

Under the circumstances, we agree with the Referee's conclusion that claimant has failed to carry his burden of proof.

ORDER

The Referee's order dated September 19, 1991 is affirmed.

July 15, 1992 Cite as 44 Van Natta 1463 (1992)

In the Matter of the Compensation of
NANCY G. BROWN, Claimant
WCB Case No. 92-06488
ORDER DENYING MOTION TO DISMISS
Royce, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

The self-insured employer has requested Board review of Referee Tenenbaum's June 25, 1992 "Order on Show Cause Proceeding." Asserting that the Referee's order is an interim order, claimant seeks dismissal of the employer's request for review. The motion to dismiss is denied.

FINDINGS OF FACT

In April 1992, the employer denied disability and medical treatment for claimant's current low back condition (including the legs, groin, buttocks, right hip, and feet) as unrelated to claimant's January 1991 compensable injury. The denial issued while the claim was in open status. In May 1992 claimant requested an expedited hearing, contending that the employer had unilaterally terminated her temporary disability. See OAR 438-06-075; 438-06-078.

A hearing convened on June 19, 1992. On June 25, 1992, the Referee issued an "Order on Show Cause Proceeding." The Referee held that the employer was not authorized to unilaterally terminate claimant's temporary disability. Consequently, the Referee directed the employer to reinstate claimant's temporary disability effective on the date the benefits had been terminated. In addition, the Referee assessed a 25 percent penalty (1/2 to be shared by claimant's attorney) based on the temporary disability award.

In reaching this decision, the Referee noted that the parties had agreed that the "substantive propriety of the [employer's] denial" was not before the Referee, but rather would be litigated before a future referee. Reasoning that the order was designed to be interim and not "litigation," the Referee did not include a statement explaining the parties' rights of appeal pursuant to ORS 656.289(3) and 656.295.

On June 30, 1992, the employer mailed by certified mail its request for Board review of the Referee's June 25, 1992 order. The request included the employer's certification that copies had been mailed to all parties to the proceeding and their representatives.

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 may finally determine one issue but not the other. Price v. SAIF, supra, at page 316; Dean v. SAIF, 72 Or App 16, 119 (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 order was expressly designated as interim. Moreover, further action concerning the "substantive propriety of the [employer's] denial" was necessary following the Referee's order. Finally, the order did not contain 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, we have recently held that, where the claimant's entitlement to temporary disability concerning a unilateral termination has been finally allowed and fixed, a Referee's order is final, notwithstanding its "interim" designation and the lack of a statement explaining the parties' rights of appeal. See Darrell D. Brown, 44 Van Natta 861 (1992).

Here, as in Darrell D. Brown, supra, the Referee's order has finally fixed claimant's right to temporary disability arising from the Referee's decision concerning the employer's unilateral termination. As such, the order is final and appealable. Inasmuch as the employer has timely and properly requested Board review, we have jurisdiction to consider the Referee's order.

Accordingly, claimant's motion to dismiss is denied. A transcript has been ordered. On its receipt, copies of the transcript will be distributed to the parties and a briefing schedule implemented. Thereafter, this case will be docketed for review.

IT IS SO ORDERED.

In the Matter of the Compensation of
FRANKLIN D. CASTEEL, Claimant
WCB Case No. 89-12388
ORDER ON REVIEW
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

Claimant, pro se, requests review of Referee Michael V. Johnson's order which: (1) affirmed a prior Determination Order award of 34 percent (65.28 degrees) scheduled permanent disability for loss of use or function of his left arm; (2) modified a prior Determination Order to award claimant a total of 60 percent (192 degrees) unscheduled permanent disability, whereas the prior Determination Order had increased claimant's total award to 99 percent (316 degrees); (3) upheld the self-insured employer's denial of claimant's aggravation claim; and (4) upheld the employer's denial of palliative treatment. In his brief, claimant moves for remand for consideration of the testimony of additional witnesses. On review, the issues are remand, premature closure, aggravation, extent of scheduled and unscheduled permanent partial disability, including permanent total disability and medical services. We deny the motion to remand. The Referee's order is affirmed in part and vacated in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact." We adopt the Referee's "Findings of Ultimate Facts" with the exception of the last sentence.

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant moves for remand to produce additional witnesses. We decline to grant 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, however, it must be shown that the evidence was not obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986). By claimant's own assertions, the evidence he seeks to submit into evidence was obtainable at the time of hearing. Claimant alleges that his attorney initially informed him that it was not necessary to bring certain witnesses to hearing, but subsequently inquired if claimant might produce such evidence at the time of hearing. Notwithstanding such allegations, we find claimant's request is insufficient to merit remand. See Diane E. Sullivan, 43 Van Natta 2791, 2792 (1991). With regard to the adequacy of claimant's representation, we note that the Workers' Compensation Board is not the proper forum for determining that issue. Diane E. Sullivan, supra. We are unable to find that the evidence claimant now seeks to produce was not obtainable with due diligence at the time of hearing. Accordingly, the motion for remand is denied.

Premature Claim Closure

We adopt the Referee's "Conclusions of Law" on the issue of premature claim closure. Claimant has not established that his claim was prematurely closed by the June 19, 1989 or September 5, 1990 Determination Orders.

Aggravation

We adopt the Referee's "Conclusions of Law" on the issue of aggravation. Claimant has not established that he has a worsened condition resulting from his original injury, as established by medical evidence supported by objective findings.

Physical Therapy

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. Here, the employer's denial is based on its contention that claimant's physical therapy is not reasonable and necessary. Original jurisdiction over such disputes is no longer shared by the Director and the Hearings Division. Stanley Meyers, 43 Van Natta 2643 (1991); Kevin Keller, 44 Van Natta 225 (1992). Rather, because such disputes do not constitute matters concerning a claim, original jurisdiction lies exclusively with the Director. See Stanley Meyers, supra; Kevin Keller, supra.

Inasmuch as the denial did not raise a matter concerning a claim within the jurisdiction of the Hearings Division, we vacate that portion of the Referee's order which determined that the requested physical therapy was not reasonable or necessary. We also dismiss claimant's hearing request on the issue, as we lack jurisdiction over this matter. See Stanley Meyers, supra; Kevin Keller, supra.

Permanent Total Disability

We adopt the Referee's "Conclusions of Law" on the issue of permanent total disability. We agree that claimant has not established that he is permanently incapacitated from regularly performing work at a gainful and suitable occupation. Furthermore, claimant has failed to establish that a combination of his medical and nonmedical factors render him permanently and totally disabled.

Extent of Scheduled Permanent Disability

We adopt the Referee's "Conclusions of Law" on the issue of extent of claimant's scheduled permanent partial disability. Claimant has not established that he is more disabled than the 34 percent scheduled permanent disability awarded by the June 19, 1990 Determination Order. Moreover, claimant has not established that the condition that gave rise to the original award or arrangement of

compensation has permanently worsened since the last arrangement or award of compensation. Stepp v. SAIF, 304 Or 375, 381 (1975).

Extent of Unscheduled Permanent Disability

We adopt the Referee's "Conclusions of Law" with regard to the April 1988 Determination Order, which awarded 20 percent unscheduled permanent disability, and the June 1989 Determination Order, which awarded an additional 40 percent unscheduled permanent disability.

Next, we address the Referee's modification of the September 5, 1990 Determination Order, which awarded claimant an additional 39 percent for a total of 99 percent unscheduled permanent disability. The Referee found that claimant's level of impairment had not changed since the issuance of the 1989 Determination Order. Therefore, he concluded that no additional award of permanent disability was appropriate. We agree.

In order to receive an increased award of permanent disability upon the closure of his most recent aggravation claim, claimant must prove that his compensable condition has permanently worsened since the 1989 Determination Order, which increased claimant's unscheduled permanent disability award from 20 percent to 60 percent. Stepp v. SAIF, supra; See Luz E. Rodriquez, 42 Van Natta 2033 (1190). For the following reasons, we find that claimant has failed to meet his burden.

At the time of the 1989 Determination Order, claimant's left shoulder ranges of motion were: 90 degrees abduction, 10 degrees external rotation, 90 degrees forward elevation, 20 degrees extension, and 20 degrees internal rotation. Applying the standards, Dr. Woolpert and the Evaluation Section rated claimant's left shoulder impairment at 18 percent.

At the time of the 1990 evaluation, claimant's left shoulder ranges of motion were: 80 degrees abduction, 35 degrees external rotation and 70 degrees forward elevation. Under the standards, claimant's total left shoulder impairment equals 15 percent. See OAR 436-35-330. There are no other objective medical findings of permanent impairment. Additionally, the persuasive medical opinion of claimant's treating doctor, Dr. Hockey, is that claimant either deliberately or unconsciously exaggerated his symptoms and gave misleading restricted ranges of motion demonstrations.

Under the circumstances, we find that claimant has failed to establish that he suffered a permanent worsening of his compensable condition since the 1989 Determination Order. Therefore, we agree with the Referee that claimant is not entitled to additional unscheduled permanent disability.

ORDER

The Referee's order dated May 24, 1991 is affirmed in part and vacated in part. That portion of the Referee's order that purported to uphold the self-insured employer's denial of palliative care is vacated. Claimant's request for hearing on that issue is dismissed for lack of jurisdiction. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
KIM LAKODUK, Claimant
WCB Case No. C2-01532
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Kirkpatrick & Zeitz, Claimant Attorney
David O. Horne, Defense Attorney

Reviewed by Board Members Neidig and Moller.

On July 1, 1992, the Board received the parties' claim disposition agreement (CDA). Pursuant to that agreement, claimant releases her rights to workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

The CDA provides that a dispute currently exists concerning the validity of the insurer's lien against claimant's third party action. Without "acknowledging or admitting the validity of either party's position" on the issue, the parties agree that the insurer is allowed an "offset" of $5,000 against the $5,750 in CDA proceeds. (The remaining $750 is payable to claimant's attorney). Finally, the insurer agrees to refrain from seeking further reimbursement for its claim costs "unless and until claimant seeks further compensation."

After consideration of this agreement, we find several provisions objectionable and contrary to law. Our conclusion is based on the following reasoning.

In essence, the "consideration" for the CDA is the insurer's reduction of its purported lien against claimant's proceeds from the disputed third party action; i.e., the insurer's $5,000 "offset" against the CDA proceeds in return for the insurer's conditional agreement not to further assert its lien. Yet, the agreement does not provide that either a "third party" settlement or judgment has been achieved.

We have previously held that, in the absence of a third party recovery, we are unable to determine the "amount to be paid the claimant" as required by OAR 436-60-145(3)(j) when a carrier reduces its lien in return for the release of claimant's workers' compensation rights. Kenneth Hoag, 43 Van Natta 991 (1991). In Hoag, we further reasoned that, despite a "partial waiver" of a third party lien by a carrier, since allocations of a third party recovery to claimant's attorney and claimant proceed any distribution to the carrier, the "value" of any "consideration" flowing to claimant as a result of a CDA where no third party recovery has been achieved is "presently not ascertainable."

Here, as in Hoag, no "third party" settlement or judgment has been achieved. Admittedly, unlike Hoag, the validity of the insurer's third party lien is in dispute and, assuming that claimant refrains from seeking further compensation, the issue will remain dormant. Nevertheless, according to a further provision in the CDA, should claimant subsequently choose to seek further compensation, the insurer's lien and its various components will become of vital importance.

Under such circumstances, we conclude that the actual consideration of this CDA is presently not ascertainable. Such a determination can only be made if, and when, claimant achieves a purported third party recovery. It is also at this time that the insurer can quantify the exact proportions of its potential third party lien.

We also object to the so-called "offset" the insurer is permitted to recover from the CDA proceeds. The CDA provides that the insurer has paid claimant all benefits "due and payable" under her accepted claim. Consequently, since all compensation has been validly provided to claimant, there is no overpayment to "offset" against the CDA proceeds. Moreover, as previously discussed, if this "offset" is intended as a reduction of the insurer's unspecified "third party" lien, the provision would be similarly objectionable because of the lack of a "third party" recovery from which to evaluate the "consideration" for the CDA.

Finally, and most importantly, we consider a portion of the agreement to be contrary to ORS 656.236(1) in that it effectively limits claimant's right to medical services under ORS 656.245. One CDA provision acknowledges that claimant retains her medical services for her compensable injury.

Nevertheless, another provision states that, should claimant seek further compensation, the insurer will no longer be restricted from asserting its "third party" lien rights. In other words, if claimant decides to seek treatment for her compensable injury to which she is lawfully entitled, the insurer has the option of attempting to recover an unspecified sum of money as reimbursement for its "third party" lien. At a minimum, such a provision has a "chilling effect" on claimant's continuing right to medical services and, as such, is unreasonable as a matter of law. See Jaylene Schwindt, 43 Van Natta 218 (1991); Diana L. Cody-Miller, 43 Van Natta 100 (1991).

In conclusion, based on the aforementioned reasoning, we find that the proposed CDA is unreasonable as a matter of law. Accordingly, we decline to approve it. The insurer's compensation obligations are reinstated in accordance with OAR 436-60-145(4)(i), and (6)(e). Following our standard procedures, we would be willing to consider a revised agreement drafted in accordance with administrative and statutory requirements.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARVIN LANE, Claimant
WCB Case No. C2-01534
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Lawrence Castle, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

On July 1, 1992, the Board received the parties' claim disposition agreement (CDA). Pursuant to that agreement, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We set aside the proposed disposition.

The CDA provides that the "consideration" for the agreement is the carrier's reduction of its lien against claimant's proceeds from a "third party lawsuit." Specifically, the carrier agrees to assert a third party lien of $23,000 rather than $37,000. The CDA does not provide that either a settlement or judgment has been achieved.

We have previously held that, in the absence of a third party recovery, we are unable to determine the "amount to be paid the claimant" as required by OAR 436-60-145(3)(j). Kenneth Hoag, 43 Van Natta 991 (1991). In Hoag, we further reasoned that, despite a "partial waiver" of a third party lien by a carrier, since allocations of a third party recovery to claimant's attorney and claimant precede any distribution to the carrier, the "value" of any "consideration" flowing to claimant as a result of a CDA where no third party recovery has been achieved is "presently not ascertainable."

Here, the CDA contains no provision indicating that a third party settlement or judgment has been recognized. Moreover, in light of the references to "claimant's proceeds in said third party action" in the agreement and the failure to expressly specify the amount of those proceeds, we conclude that no third party recovery has been achieved.

Consequently, in accordance with reasoning articulated in Hoag, we find that the proposed CDA is unreasonable as a matter of law. Accordingly, we decline to approve it.

IT IS SO ORDERED.

In the Matter of the Compensation of
KERMIT S. MELING, Claimant
WCB Case Nos. 89-22568 & 91-09769
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys
C. Douglas Oliver (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Liberty Northwest Insurance Corporation requests review of Arbitrator Galton's order that: (1) set aside its aggravation denial of claimant's low back claim; and (2) upheld the SAIF Corporation's denial of claimant's "new occupational disease" claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the Arbitrator's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

We review the Arbitrator's order solely on questions of law. ORS 656.307(2); Timothy R. Schroeder, 41 Van Natta 568 (1989). Here, the applicable law is ORS 656.308, pursuant to which an insurer that is responsible for a compensable injury remains responsible for continued or increased disability during employment with a later carrier, unless the claimant sustains a new injury or occupational disease during the subsequent employment. See Donald C. Moon, 43 Van Natta 2679 (1991).

The Arbitrator concluded that Liberty remained responsible for claimant's compensation. On review, Liberty contends that the Arbitrator did not apply the correct law because he characterized claimant's claim with regard to SAIF's insured as one for an occupational disease, rather than an accidental injury. We agree with the Arbitrator's conclusion that claimant's condition is properly analyzed as an occupational disease.

To determine whether a claim is properly considered as a new injury or an occupational disease, we apply a two-part analysis. The test requires a determination of whether the claimed medical condition was unexpected or expected, and whether the onset was sudden or gradual. O'Neal v. Sisters of Providence, 22 Or App 9 (1975); Valtinson v. SAIF, 56 Or App 184 (1982).

The first prong of the test requires a retrospective estimation of the likelihood that the medical condition claimed would result from the kind, rate and duration of activity or exposure alleged to be the cause of the condition. Sisters of Providence, supra. If the condition claimed was not unlikely to follow such activity or exposure, an occupational disease is suggested. If the condition claim was not expected from such activity or exposure, an industrial injury is indicated.

In the present case, we do not find that it is unlikely that claimant's low back pain would result from his work activity with SAIF's insured. Claimant testified that the workload increased in February 1991 and he was required to do more bending and lifting of larger pieces than he previously lifted. Moreover, claimant had previously been permanently restricted to lifting no more than 35 pounds, and Dr. Richardson reported in December 1990, that claimant would continue to have mild to moderate chronic back pain. Under the circumstances, we find that claimant's back condition was not unlikely to follow his lifting and bending activity at work. Accordingly, we conclude that the facts of this case suggest an occupational disease analysis.

Additionally, we find this case to be distinguishable from the cases cited by Liberty on review. In Patrick P. Horstman, 42 Van Natta 1288 (1990), we concluded that a worker's activity of operating lathes and tightening the lathes for two and one-half days was unlikely to result in the claimed shoulder condition. In the instant case, however, claimant's increased workload, which required him to bend

more frequently and to lift heavier objects than he was previously lifting, began in February 1991 and continued until he had to leave work in April 1991 due to the low back condition. Furthermore, we again note that it is not unlikely that the kind and duration of such work would result in claimant's low back condition. Moreover, for the same reasons, we also find this case distinguishable from Carol A. Fisher, 42 Van Natta 921 (1990), in which we concluded that a two-day increase in work activity would not have been expected to result in claimant's worsened spondylolysis condition.

The second prong of the test requires definition of the phrase "sudden onset." In Valtinson v. SAIF, supra, the court did not equate "sudden" with instantaneous. It ruled that the onset of a condition is "sudden" if it occurs as a result of a "discrete period" of work activity or exposure, as compared to the onset of an occupational disease over a long period of time.

Liberty contends that claimant's case is similar to Carol A. Fisher, supra. Liberty argues that in Fisher, the Board found an accidental injury although the claimant's strenuous work activity was over a two-day period. Liberty also argues that in Patrick P. Horstman, supra, the Board found that the claimant's work over a two-and a-half day period was sufficiently discrete to constitute the requirement that an injury be sudden in onset.

We again find the cases cited by Liberty to be distinguishable from the present case. Here, claimant testified that before he began work with SAIF's insured, he was still continuing to receive chiropractic treatments and occasional anti-inflammatories for his back. (Tr. 31). Claimant stated that, although his back had improved, he still continued to experience pain and he never returned to "100 percent." Moreover, although claimant sought treatment following a three-day period in which his workload was increased, he remained at work performing the same tasks and experiencing progressive deterioration of his condition until he had to leave work on April 18, 1991, due to his low back condition. (Tr. 33-37). Finally, the medical reports and claimant's testimony establish that there was no specific incident at work which caused his increased low back pain. (Exs. 49, 60, 61).

We conclude that the facts of the case establish both that claimant's condition was not unexpected and that his condition was not sudden in onset. Accordingly, we agree with the Arbitrator's analysis of this case as an occupational disease.

We, therefore, affirm the Arbitrator on the issue of responsibility.

ORS 656.382(2) authorizes a fee when claimant's right to compensation is at risk of disallowance or reduction. Ray Schulten's Ford v. Vijan, 105 Or App 294 (1991).

Here, claimant's right to compensation was not at risk of disallowance because a ".307" order issued prior to hearing. However, claimant's right to compensation was at risk of reduction. The Arbitrator assigned responsibility to Liberty, which had the higher rate of temporary disability compensation. Thus, claimant's rate of compensation could have been reduced had Liberty's appeal proved successful. Inasmuch as there was a risk that claimant's compensation would be reduced had we reversed the Arbitrator's order and found SAIF responsible, we conclude that claimant is entitled to an insurer-paid attorney fee for services on review, to be paid by Liberty. See International Paper Company v. Riggs, 114 Or App 208 (1992); Ray Schulten's Ford v. Vijan, supra; Richard H. Long, 43 Van Natta 1309 (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 $500, to be paid by Liberty. 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 Arbitrator's order dated November 18, 1991 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $500, payable by Liberty.

In the Matter of the Compensation of
SHERRY A. SHERIDAN, Claimant
WCB Case Nos. 90-20787 & 90-19578
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Daryl Nelson, Defense Attorney
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Liberty Northwest Insurance Corp. (Liberty) requests review of Referee Peterson's order that: (1) set aside its denial of claimant's aggravation claim for a right arm condition; (2) upheld the SAIF Corporation's denial of claimant's aggravation claim for the same condition; and (3) ordered payment of temporary disability commencing July 31, 1990 and continuing until appropriately terminated under the law. On review, the issues are compensability, responsibility, and temporary disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exception and supplementation. We do not adopt the second sentence of the fifth paragraph.

Claimant began treating with Dr. Long, M.D., in September 1987. (Ex. 12). She continued treating with Dr. Long and was last examined by Long on July 19, 1990. As a result of right arm and forearm pain, claimant went to the emergency room on July 4, 1990. On July 19, 1990, claimant returned to Dr. Long who noted "clinical but not electrodiagnostic evidence of radial entrapment neuropathy in the right supinator area." (Ex. 35-2).

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).

Liberty requested review of the Referee's order; however, none of the parties filed a brief regarding this case. After our de novo review of the record, we adopt the Referee's reasoning and conclusions regarding the issues of compensability and temporary disability.

We write only to address the responsibility issue. The Referee found that Liberty was responsible for claimant's current condition. We agree.

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."

Here, claimant suffered two discrete injuries to her right upper extremity. In both injuries a patient grabbed, pulled, and twisted claimant's right forearm. The first injury occurred in 1987 and was accepted by SAIF. The second injury occurred in 1989 and was accepted by Liberty. The question of responsibility in this unusual case turns on identifying the condition which requires treatment.

Two medical opinions discuss the cause of claimant's current condition. Dr. Long opined that claimant's current condition is caused by a muscle pain condition. He opined that claimant's condition after the initial injury in 1987 included median nerve compression and some element of muscular pain in the right forearm and perhaps the right shoulder girdle and arm. (Ex. 90-21). The median nerve injury

resolved following surgery. (Exs. 63-2, 90-12, 90-14, 90-29). Dr. Long opined that the muscular or myofacial pain element resulting from the 1987 injury improved but did not completely resolve, leaving her with a chronic muscular condition. (Exs. 90-13, 90-21). He also found that the 1989 injury caused problems that were of muscular origin, not related to any nerve entrapment. (Exs. 88, 90-9, 90-29). Furthermore, he opined that the 1989 incident was a new injury that caused a significant worsening of the chronic muscular pain problem. (Exs. 88, 90-14, 90-15, 90-16, 90-17, 90-22). He ultimately opined that the 1989 injury is responsible for claimant's current condition.

On the other hand, Dr. Puziss, treating orthopedist, opined that the 1987 injury caused a right radial nerve compression at the elbow in addition to the median nerve compression. (Exs. 82, 86). Dr. Puziss opined that this radial nerve condition is the cause of claimant's current problems and the major contributing cause of the radial condition is the 1987 injury. Id.

We find Dr. Long's opinion more persuasive. Dr. Long has a longer treatment history with claimant, which includes the periods after the 1987 and 1989 injuries. Also, Dr. Long explained that the nerve conduction studies he performed in February 1990 showed no evidence of any lesion at the radial nerve. (Ex. 90-27). He also explained that it was difficult to distinguish a lesion from muscle pain on the basis of a clinical examination alone. Id. Dr. Puziss made his diagnosis on the basis of his clinical examination without any nerve conduction studies. In addition, Dr. Puziss does not explain the lack of evidence of a radial compression in the February 1990 nerve conduction test, the last one performed. Also, Dr. Long's opinion that the second injury is responsible for claimant's current condition is supported by the opinions of Dr. Layman, consulting surgeon, and Dr. Barnhouse, former treating M.D. (Exs. 87, 89). For these reasons, we find Dr. Long's opinion more persuasive.

Liberty accepted the claim for this second injury and there has been no subsequent injury. Therefore, Liberty remains responsible for the medical services and disability related to the second compensable injury. ORS 656.308(1).

ORDER

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

In the Matter of the Compensation of
CARL SMITH, Claimant
WCB Case No. 91-05815
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Claimant requests abatement and reconsideration of our June 19, 1992 Order on Review. In that order, we reversed that portion of the Referee's order finding that the order on reconsideration issued by the Director was invalid on the ground that it lacked findings by a medical arbiter. Concluding that we had jurisdiction to consider the order on reconsideration, we further found that the medical evidence failed to establish entitlement to impairment for loss of grip strength or for a chronic condition limiting repetitive use of claimant's right hand. Therefore, we reduced the scheduled permanent disability award provided by the order on reconsideration from 22 percent to 5 percent, as awarded by the notice of closure. Based on this finding, we concluded that claimant was not entitled to penalties under ORS 656.268(4)(g) and (e) or an assessed attorney fee under ORS 656.382(1). Furthermore, we affirmed and adopted that portion of the Referee's order that directed the employer to pay claimant's scheduled permanent disability award at the rate of $305 per degree.

In his request for abatement and reconsideration, claimant asserts that the "Board misinterpreted evidence in the record in coming to the conclusion that claimant should receive no award for grip strength loss." Specifically, claimant contends that he is entitled to such an award based on grip measurements taken by his treating physician, Dr. Streitz, in August 1990 "when there was no question about whether there may have been some contribution from some condition other than the industrial

injury." Claimant also continues to assert that he is entitled to an award for a chronic condition limiting repetitive use of his right hand. The employer has submitted a response to claimant's request.

Our order appropriately considered the measurements of grip strength taken by Dr. Streitz in August 1990, as well as his most recent measurements and accompanying narrative of October 29, 1990. Although claimant argues that our interpretation of Dr. Streitz's statements in his October 29, 1990 letter is wrong, we are not persuaded by the reasons given for construing the medical evidence in a different manner from that provided in our order on review. In this regard, as relevant, Dr. Streitz's October 29, 1990 narrative report states:

> "In response to [claimant's counsel's] question, I feel he probably has some chronic residuum of his wrist injury, but he evidently is being quite active caring for his cows and sheep. I would say in general the dominant hand is somewhat stronger than the nondominant hand. Grip strength is somewhat subjective. I think grip strength differences were related to his wrist dislocation injury, however, those of today may be erroneous in that he is also having the tendinitis associated with his heavy work." (Ex. 11).

It may be, as claimant argues, that Dr. Streitz's statement concerning a comparison between the dominant hand and the nondominant hand is intended to refer to people in general rather than to claimant in particular. In this regard, perhaps Dr. Streitz's statement is made in response to a general question contained in claimant's counsel's inquiry. However, claimant's counsel's letter is not included in the record and, therefore, we can only speculate as to its contents.

Regardless, in light of the remainder of Dr. Streitz's narrative, we continue to conclude that we are unable to find any ratable loss of grip strength. Dr. Streitz's statement that claimant "probably" has some chronic residuum of this wrist injury, combined with the discussion of claimant's tendinitis condition and its effect on claimant's continued loss of grip strength both call into question the permanency of claimant's injury-related loss of grip strength, as well as render any rating of the injury-related component, if any, of claimant's loss of grip strength speculative. Under these circumstances, we are unable to accept claimant's interpretation of Dr. Streitz's report or claimant's suggestion that we rely on the earlier grip strength findings. We also continue to be convinced that the medical evidence fails to demonstrate a chronic condition limiting repetitive use of claimant's right hand.

In its response, the employer asserts that the award of $300 to claimant's attorney for prevailing against its request for review concerning the proper rate of scheduled disability is excessive. We first note that, subsequent to our order on review, the Court of Appeals reversed our decision in Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), where we held that the rate of $305 per degree provided by ORS 656.214(2) applies to awards made on or after May 7, 1990, regardless of the date of injury. The Court of Appeals concluded that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992).

The attorney fee award on review was based on that portion of our order that affirmed the Referee's order directing the employer to pay claimant's scheduled permanent disability award at the rate of $305 per degree. In view of the decision in SAIF v. Herron, supra, we must vacate that portion of our order awarding an attorney fee as well as reverse that portion of our order concerning the rate of scheduled permanent disability. Based upon our finding that claimant was injured before May 7, 1990, (Ex. 6), amended ORS 656.214(2) does not apply. Id. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury. ORS 656.202(2); former ORS 656.214(2).

Upon reconsideration, we withdraw our June 19, 1992 order. On reconsideration, as supplemented herein, we adhere to and republish our June 19, 1992 order except for those portions that affirmed the Referee's order directing the employer to pay claimant's scheduled permanent disability award at the rate of $305 per degree and awarding an assessed attorney fee to claimant's counsel for prevailing against the employer's request for review concerning the rate of scheduled disability. Claimant is entitled to the rate of scheduled permanent disability compensation as provided by this

order. That portion of our order awarding an attorney fee is vacated. 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
DEBBIE L. STADTFELD, Claimant
WCB Case No. 91-02701
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Menashe's order that: (1) authorized the insurer to offset temporary disability benefits paid between July 25, 1990 and December 5, 1990 ($3,178.28); and (2) declined to assess a penalty for an allegedly unreasonable offset of temporary disability benefits paid between July 25, 1990 and December 5, 1990. The insurer cross-requests review of those portions of the order that: (1) declined to authorize an offset for temporary disability benefits paid between June 26, 1989 and July 25, 1990 ($5,075.00); and (2) assessed a penalty for an allegedly unreasonable offset of temporary disability benefits paid between June 26, 1989 and July 25, 1990. In its brief, the insurer also contends that the Referee lacked jurisdiction to consider claimant's objection to its offset of the overpayment created by the December 5, 1990 Determination Order. On review, the issues are jurisdiction, offset and penalties. 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 supplementation.

On October 23, 1991, the Court of Appeals affirmed the Board's January 18, 1991 Order on Review which reinstated the June 26, 1989 Determination Order's March 7, 1989 medically stationary date and awarded a total of 34 percent permanent partial disability. Stadtfeld v. Pony Express Courier, 109 Or App 329 (1991).

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The insurer argues that the Referee did not have jurisdiction concerning claimant's objection to its offset, contending that claimant should have litigated that issue before the Board or the court, pursuant to its appeal from the June 26, 1989 Determination Order. We disagree.

Claimant does not object to the offset authorized by the June 26, 1989 Determination Order. The insurer's subsequent deduction did not occur until after the Board's January 18, 1991 Order. Because there was no offset, claimant had no reason to complain and no offset issue was ripe or raisable until after the insurer's deduction. Consequently, the insurer's "jurisdictional" argument is without merit. See e.g. SAIF v. Zorich, 94 Or App 661 (1989).

Offset

The Referee authorized the insurer to offset temporary disability benefits paid between March 7, 1989 and June 26, 1989 ($2,600.25). The parties do not contest this portion of the Referee's order and we agree that an offset should be allowed. The Referee also authorized the insurer to offset temporary disability benefits paid between July 25, 1990 and December 5, 1990 ($3,178.28). We disagree.

ORS 656.313(1) allows a carrier to stay payment of certain types of compensation pending review or appeal. However, ORS 656.313(2) provides:

> "If the board or court subsequently orders that compensation to the claimant should not have been allowed or should have been awarded in a lesser amount than awarded, the claimant shall not be obligated to repay any such compensation which was paid pending review or appeal."

ORS 656.313(2) has been interpreted to apply to requests for offset of temporary disability benefits paid pending appeal or review. Hutchinson v. Louisiana-Pacific, 67 Or App 577, 581 rev den 297 Or 340 (1984); Hector Delhorno, 43 Van Natta 1221 (1991); Josephine M. Gantt, 42 Van Natta 483 (1990).

Here, the earlier Referee found that claimant's claim had been prematurely closed and remanded the matter to the insurer for processing. The insurer requested review of the Referee's order. However, by virtue of the earlier Referee's order, the insurer commenced paying temporary disability benefits as of June 26, 1989 and paid such benefits until December 5, 1990.

Inasmuch as the temporary disability compensation paid from June 26, 1989 through December 5, 1990 constituted compensation paid pending appeal, the insurer is not entitled to offset those benefits under ORS 656.313(2). Hutchinson, supra; Delhorno, supra. Accordingly, we modify the Referee's order to allow an offset only for those temporary disability benefits paid from March 7, 1989 through June 26, 1989 ($2,600.25).

Penalties

The Referee found that the insurer's unilateral offset of claimant's permanent disability award was unreasonable, and assessed a penalty based on the amount of permanent disability not subject to offset ($5,101.47). We agree that the insurer's action was unreasonable, but modify the amount of the penalty.

A penalty may be assessed when a carrier "unreasonably delays or unreasonable refuses to pay compensation." ORS 656.262(10). An insurer may not unilaterally recoup an overpayment, but first must obtain approval from the Evaluation Division, a referee or the Board. Forney v. Western States Plywood, 66 Or App 155 (1983).

Here, the insurer did not pay claimant's award of permanent disability on the basis of its belief that it was entitled to offset allegedly overpaid temporary disability compensation. However, as noted above, the insurer may not unilaterally recoup an overpayment without authorization. Id. Moreover, the insurer's actions are contrary to law as ORS 656.313(2) expressly provides that, should the Board subsequently order that compensation paid to claimant pending Board review should not have been allowed or should have been awarded in a lesser amount than awarded, claimant shall not be obligated to repay any such compensation. Hutchinson, supra; Delhorno, supra.

Under these circumstances, we find the insurer's failure to pay claimant's permanent disability award was unreasonable. Accordingly, we assess a 25 percent penalty on all compensation due claimant ($8,279.75). ORS 656.262(10).

ORDER

The Referee's order dated July 24, 1991 is reversed in part, modified in part and affirmed in part. That portion which authorized an offset of temporary disability benefits paid between July 25, 1990 and December 1990 is reversed. That portion which awarded a 25 percent penalty based on $5,101.47 is modified. In lieu of that penalty, claimant is awarded a penalty equal to 25 percent of all compensation due ($8,279.75). From the penalty, one-half is payable to claimant and one-half is payable to claimant's counsel. The remainder of the order is affirmed.

In the Matter of the Complying Status of
SUNSET SIDING CONSTRUCTION, INC., Noncomplying Employer
WCB Case No. 91-00509
ORDER OF DISMISSAL
Christopher Rounds, Attorney
Breathouwer, et al., Attorneys
Saif Legal Department, Attorney
Bottini, et al., Attorneys
Dunn, et al, Attorneys

Mutual of Omaha Insurance Company and Sunset Siding Construction have moved the Board for an order dismissing claimant's request, and Masterpiece Construction's cross-request, for review of Referee Crumme's order which set aside a Director's order finding Sunset to be a noncomplying employer and set aside the SAIF Corporation's acceptance of claimant's injury claim on behalf of Sunset. Contending that the only issues litigated at hearing were the Director's noncompliance order and whether Sunset or its general contractor, Masterpiece, were responsible for claimant's injury claim, Mutual of Omaha and Sunset argue that "no matters concerning a claim" were contested at the hearing. Relying on ORS 656.740(4), Mutual of Omaha and Sunset argue that appellate review does not rest with the Board.

In response to the motion to dismiss, claimant has withdrawn his request for Board review and Masterpiece acknowledges that "it appears under the current case law the Board does not have jurisdiction of this particular non-complying employer issue." We grant the motion to dismiss.

FINDINGS OF FACT

On December 14, 1990, the Compliance Section issued a Proposed and Final Order of Noncompliance, which found Sunset Siding, as of the date of claimant's injury, to be a subject employer and to lack workers' compensation insurance. Thereafter, the SAIF Corporation, on behalf of Sunset Siding, accepted claimant's injury claim pursuant to ORS 656.054.

Sunset requested a hearing concerning the Noncompliance Order and SAIF's acceptance of the claim. Acknowledging that it was a subject employer and that claimant was a subject worker, Sunset further conceded that claimant was injured within the course and scope of his employment. However, Sunset contended that Masterpiece Construction, its general contractor, was responsible for the claim under ORS 656.029. Finally, Sunset asserted that a representative of Mutual of Omaha had orally represented that Sunset had workers' compensation coverage through Mutual of Omaha.

At the commencement of the hearing, the parties stipulated that: (1) Sunset was a subject employer; (2) claimant was a subject worker; and (3) claimant was injured within the course and scope of his employment. Thus, the issues litigated at hearing pertained to whether Sunset was a noncomplying employer and, if so, whether Masterpiece was responsible for the claim under ORS 656.029.

Following the hearing, the Referee issued an order concluding that Sunset was a noncomplying employer and that Masterpiece was responsible for claimant's injury claim under ORS 656.029. Consequently, the Referee set aside the noncompliance order, as well as SAIF's acceptance of the claim on behalf of Sunset. Relying on ORS 656.740(4)(c), the Referee noted that the parties objecting to the order should seek Board review. Thereafter, claimant, Sunset, and Masterpiece filed their respective requests for Board review of the Referee's order.

CONCLUSIONS OF LAW AND OPINION

When a Referee issues an order concerning a Director's order of noncompliance or any other matter unrelated to a claim, the Referee's order becomes a final order of the Director and must be appealed directly to the Court of Appeals. ORS 183.480(1); Denise K. Rodriguez, 40 Van Natta 1788 (1988). We review such orders only when an order declaring a person to be a noncomplying employer is contested at the same hearing as a matter concerning a claim. ORS 656.740(4)(c); Derwin W. Wilson, 43 Van Natta 360 (1991). Matters concerning a claim are those matters in which a worker's right to

receive compensation, or the amount thereof, are directly in issue. ORS 656.704(3). When an alleged noncomplying employer requests a hearing from SAIF's acceptance of the claim on the employer's behalf, but only contests noncompliance at the hearing, we lack jurisdiction over the appeal. See Larry J. Powell, 42 Van Natta 1594 (1990).

Here, Sunset requested a hearing challenging, among other issues, SAIF's acceptance of the claim on Sunset's behalf. Nevertheless, in raising this challenge, Sunset acknowledged that it was a subject employer, claimant was a subject worker, and that claimant's injury arose within the course and scope of his employment. Thus, the basis for Sunset's objection to the noncompliance order and SAIF's acceptance was that either Mutual of Omaha was estopped from denying that it provided workers' compensation coverage to Sunset or that Masterpiece was responsible for claimant's injury claim under ORS 656.029. Moreover, prior to the commencement of the hearing, the parties stipulated to Sunset's statement of the issues.

Thus, it was uncontested that claimant's injury arose out of the course and scope of his employment and that some entity was responsible for his claim for benefits. In other words, claimant's right to receive compensation, or the amount thereof, was not directly at issue. See ORS 656.704(3). Inasmuch as the only issues contested at hearing pertained to Sunset's alleged noncompliance status, we are without authority to consider this appeal. See Derwin W. Wilson, supra; Larry J. Powell, supra.

In reaching this conclusion, we recognize that the Referee's statement of appeal rights may have misled the parties. Yet, our jurisdiction is statutory and an incorrect statement of appeal rights cannot expand or contract our jurisdiction. Derwin W. Wilson, supra; Gary O. Soderstrom, 35 Van Natta 1710 (1983). Moreover, we note that, in light of claimant's withdrawal of his request for review and Masterpiece's response to the motion to dismiss, the remaining parties to this proceeding recognize that jurisdiction over this dispute does not rest with this appellate forum.

Accordingly, the requests for Board review are dismissed.

IT IS SO ORDERED.

July 15, 1992 Cite as 44 Van Natta 1477 (1992)

In the Matter of the Compensation of
KENNETH M. WAGNER, Claimant
WCB Case No. 91-03498
ORDER ON RECONSIDERATION
Welch, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney

On July 10, 1992, we withdrew our June 10, 1992 Order on Review which had reversed a Referee's order that had set aside the insurer's denial of claimant's aggravation claim for a herniated disc. We took this action to retain jurisdiction to consider the parties' proposed settlement.

The parties have now submitted a proposed "Disputed Claim Settlement and Stipulation and Order of Dismissal," which is designed to resolve all issues raised or raisable in this matter, in lieu of all prior orders. Specifically, claimant agrees that the insurer's denial "shall forever remain in full force and effect."

Pursuant to the settlement, the parties agree that this matter shall be dismissed with prejudice. In addition, it is our understanding that claimant's attorney shall receive a $2,750 fee payable from the $11,000 settlement proceeds, as well as a $2,000 extraordinary fee payable by the insurer in addition to the proceeds. Based on this understanding, we have approved the parties' agreement, thereby fully and finally resolving this matter, in lieu of all prior orders. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT L. ADLER, Claimant
Own Motion No. 91-0720M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation requests reconsideration of that portion of our Own Motion Order on Reconsideration dated June 23, 1992 which awarded a penalty-related attorney fee for unreasonable resistance to the payment of compensation. Specifically, SAIF contends its processing of claimant's own motion order request was not unreasonable because: (1) evidence that claimant was working as an apartment manager is insufficient to show that he was in the work force; and (2) claimant failed to timely respond to SAIF's request for evidence that claimant was receiving income. SAIF cites Doris M. Seibert, 44 Van Natta 377 (1992) in support on its contention. SAIF's argument is unpersuasive for several reasons.

First, unlike Seibert, the present claimant was found to be in the work force while he was working as an apartment manager. Accordingly, the facts in Seibert are not analogous to the instant case. Further, SAIF indicates that Seibert holds that employment as an apartment manager is one in which it is reasonable to doubt that wages are earned, and therefore, SAIF's reliance on that finding in Seibert was a reasonable basis to doubt that claimant, in the present case, was earning wages as an apartment manager. We find that such an interpretation of Seibert is erroneous.

A reading of Seibert does not convince us that the Board held that a person working as an apartment manager is most likely not earning wages. Further, we find no precedent for such a finding. Moreover, we find that SAIF could not have relied, albeit incorrectly, upon its interpretation of Seibert as the basis of its denial. Notably, Seibert was decided February 28, 1992, after SAIF's December 19, 1991 recommended denial.

Upon reconsideration, we note that the record establishes that at the time of its denial recommendation, SAIF had evidence that claimant "had a four month job as a manger of an apartment complex." SAIF also had evidence that claimant was self-employed operating under the assumed business name of "Adler Investigation." We further note that SAIF does not contest that claimant was working as an apartment manager, nor does SAIF contest that claimant was self-employed. Rather, SAIF asserts that an apartment manager job does not conclusively establish that claimant was receiving wages. Significantly, SAIF does not assert the same argument in regard to claimant's self-employment endeavors. We find that SAIF possessed evidence which supported a finding that claimant was in the work force. SAIF has not offered any documentation to the contrary to support its original contention that it had reason to doubt that claimant was not in the work force. We acknowledge SAIF's concerns in regard to the claimant's untimely response to its letter. However, based on the foregoing findings and the record as a whole, we find that SAIF's denial was an unreasonable resistance of the payment of compensation.

Accordingly, we withdraw our Own Motion Order on Reconsideration dated June 23, 1992. On reconsideration, as supplemented herein, we republish our June 23, 1992 order on reconsideration. 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
LAURIE H. ARNDT, Claimant
WCB Case No. 91-12484
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

The SAIF Corporation requests review of Referee Galton's order that directed it to pay claimant's scheduled disability award at the rate of $305 per degree. On review, the issue is rate of scheduled disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's award of scheduled permanent disability should be paid at the rate of $305 per degree. He relied on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), in which we held that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. Subsequent to the Referee's order, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992).

In this case, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury, which, in this case, is $145. ORS 656.202(2); Former ORS 656.214(2).

ORDER

The Referee's order dated January 8, 1992 is reversed.

In the Matter of the Compensation of
RALPH D. EARHART, JR., Claimant
WCB Case No. 91-01848
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Garrett, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Davis' order that upheld the self-insured employer's denial of claimant's current low back condition. On review, the issue is compensability.

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

Claimant argues on review that his current low back condition (a herniated disc at the L4-5 level) is encompassed in the employer's acceptance of his June 23, 1989 low back injury claim. Therefore, claimant contends that the employer's February 8, 1991 denial is an impermissible back-up denial. We disagree.

Acceptance of a claim encompasses only those conditions specifically accepted in writing. Johnson v. Spectra Physics, 303 Or 49 (1987). Here, the employer did not issue a formal acceptance. On the 801 form, the body part affected was identified as "left lower back" and the nature of the injury as "dislocation." (Ex. A). Dr. Buza, claimant's treating neurosurgeon, diagnosed a disc with "L5-S1 radiculopathy on the left" (Ex. 1A-2), and on September 28, 1989, performed a laminectomy of the ruptured and calcified L5-S1 disc on the left (Ex. 2). The employer paid for the September 1989 surgery. Although the initial MRI on July 7, 1989 revealed "focal protrusion of the degenerating and narrowed L4-5 disc on the right," this finding had no apparent effect on the nerve roots and required no treatment at that time. (Ex. 1).

A Determination Order issued April 24, 1990, finding claimant to be medically stationary on March 14, 1990, and awarding 31 percent unscheduled permanent disability. Subsequently, while loading firewood in October or November 1990, claimant felt a "pop" in his low back, became unable to stand up, and experienced significant pain.

On January 28, 1991, independent medical examiners Dr. Brooks, neurologist, and Dr. Fry, orthopedist, examined claimant and opined that the L4-5 disc degeneration was not a consequence of the June 1989 injury, but that claimant had the degenerated disc condition prior to the June 1989 injury. (Ex. 10-6 to -7). Dr. Buza also opined that the L4-5 disc degeneration was not a sequela of the June 1989 injury, but was a chronic condition due to age. (Ex. 12-1; see also, Ex. 13-16). Regarding the cause of claimant's current L4-5 disc herniation, Dr. Buza opined that it was caused by either the firewood lifting incident or claimant's degenerative disc disease, with the latter being the more likely cause. (Ex. 13-17).

On the medical record before us, we cannot conclude that the degenerative disc condition at L4-5 was encompassed in the employer's acceptance of the June 1989 injury. If a carrier accepts the symptoms of a disease, the acceptance encompasses the disease itself as well. See Opha D. Richards, 44 Van Natta 1229 (1992). Here, however, the employer did not accept the symptoms of a disease or condition; it accepted a "dislocation" of the left lower back. The medical evidence does not support a finding that the "dislocation" is a symptom of degenerative disc disease. See Patricia C. Mellott, 43 Van Natta 1454 (1991) (degenerative disc disease not within scope of acceptance where body part affected was "vertebrae in back" and claimant was treated for back and neck strain). Without such evidence, we cannot conclude that the employer's acceptance encompassed claimant's degenerative disc disease. See Electric Mutual Liability Ins. Co. v. Automax, 113 Or App 531 (1992). Accordingly, we find that the employer's denial of claimant's current condition and need for medical treatment is not an impermissible back-up denial.

ORDER

The Referee's order dated October 25, 1991 is affirmed.

July 16, 1992 Cite as 44 Van Natta 1480 (1992)

In the Matter of the Compensation of
CAROLE A. HEEGLE, Claimant
WCB Case Nos. 90-21341 & 91-02239
ORDER ON RECONSIDERATION
Charles Robinowitz, Claimant Attorney
Daryl Nelson, Defense Attorney

Claimant requests reconsideration of that portion of our June 30, 1992 Order on Review which did not assess an attorney fee for her counsel's services on review because no brief was submitted.

In support of her request for attorney fees, claimant has submitted a statement of services, documenting her attorney's efforts on her behalf subsequent to the insurer's September 16, 1991 request for review. (For example, phone conferences with claimant, her physician and the Department; correspondence with the insurer; and review of the record). Having considered this documentation, we conclude that claimant's counsel actually performed services on review. Therefore, claimant's counsel is

entitled to a reasonable attorney fee for prevailing over the insurer's request for review concerning the compensation awarded to claimant. See ORS 656.382(2); Dan W. Hedrick, 38 Van Natta 208 (1986), aff'd mem. 83 Or App 275 (1987) (Although no briefs were filed, claimant's counsel provided legal representation which supported a fee award on review); Mobley v. SAIF, 58 Or App 394 (1982). However, claimant's counsel is not entitled to an assessed fee for time expended regarding the attorney fee issue, because attorney fees do not constitute "compensation awarded to a claimant" under ORS 656.382(2). See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

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 $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 statement of services), the complexity of the issue, and the value of the interest involved.

We withdraw our June 30, 1992 order. On reconsideration, we adhere to and republish our June 30, 1992 order, as supplemented herein, effective this date. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

July 16, 1992 Cite as 44 Van Natta 1481 (1992)

In the Matter of the Compensation of
GERALD K. MAEL, Claimant
WCB Case Nos. 91-05666, 90-21844 & 91-02677
ORDER ON REVIEW
Jon L. Woodside, Claimant Attorney
Roberts, et al., Defense Attorneys
C. Douglas Oliver (Saif), Defense Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Home Insurance Company requests review of Referee Schultz' 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 "new injury" claim for the same condition on behalf of its insured, Sunset Chevron; and (3) upheld SAIF's denial of claimant's aggravation claim for the same condition on behalf of its insured, Savin Northwest. On review, the issues are compensability and responsibility. 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 exceptions. We do not adopt the first, third and fourth finding of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Responsibility

Here, claimant worked for the same employer, Savin Northwest (Savin), during the entire period in question. On December 8, 1988, claimant injured his low back while working for Savin. SAIF (hereinafter SAIF/Savin), accepted claimant's lumbar strain claim. In July 1990 and December 1990, claimant suffered increased symptoms following lifting incidents at Savin, who was insured by the Home Insurance Company (Home/Savin) at that time. Also, claimant worked a second job at Wes's Chevron beginning in September 1990. That company was also insured by SAIF (SAIF/Chevron).

The Referee found that there was no evidence of any injury as a result of claimant's work at SAIF/Chevron's insured. We adopt the Referee's reasoning and conclusion regarding the issue of SAIF/Chevron's responsibility. The Referee also found that claimant had sustained a new compensable

injury in 1990 as a result of his work at Savin and that, as a result, responsibility shifted to Home/Savin. We disagree.

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 ORS 656.308(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); see also Ronald L. Rushton, 44 Van Natta 124 (1992). Thus, SAIF/Savin, as the last insured against whom claimant had an accepted low back injury, remains presumptively responsible. In order to avoid responsibility, SAIF/Savin has the burden of establishing that claimant sustained a new compensable injury involving the same condition while working for Home/Savin's insured.

In order to prove a "new compensable injury," SAIF/Savin must show that the 1990 incidents were a material contributing cause of disability or need for treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991). The new 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). However, it is not SAIF/Savin's burden to establish that the incidents while claimant worked for Home/Savin's insured were the major contributing cause of claimant's condition, because ORS 656.005(7)(a)(B) is not applicable in the responsibility context. Rosalie S. Drews, 44 Van Natta 36, 38 (1992).

Claimant stated that his low back had not been completely pain free since the 1988 injury and that the July 1990 incident caused him to feel more pain in the same area. (Ex. 35A-7). Claimant's statement suggests that he did not suffer a new injury, but had only increased symptoms from his 1988 compensable injury. See Taylor v. Mult. School District, 109 Or App 499 (1991). However, although claimant's statement is probative, whether claimant suffered a "new injury" in 1990 is a complex medical question the resolution of which 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 the opinions of Dr. DiPaola, claimant's treating orthopedist, Dr. Case, an orthopedist, and Dr. Watson, a neurologist. The latter two doctors are employed by Western Medical Consultants, Inc. and performed an independent medical examination of claimant on October 19, 1990.

Although Dr. DiPaola uses the term "resprain" or "reinjury" in three of his reports following the 1990 incidents, we do not find that he opined that claimant sustained a new injury as a result of the 1990 incidents. We base this finding on Dr. DiPaola's explanation that the "reinjury" "represents an exacerbation of [claimant's] previous work injury and that his claim should be reopened." (Ex. 27). Also, Dr. DiPaola characterized claimant's condition following the July 1990 incident as a recurrence of low back pain and a recurrent back strain. (Exs. 12-3, 12-4). In addition, Dr. DiPaola stated that claimant's condition was "an aggravation of his original industrial injury which continues to be the major contributing cause of his current condition." (Ex. 29-3). We conclude that Dr. DiPaola's opinions, taken as a whole, establish that claimant's disability and need for treatment in 1990 were caused by the initial 1988 injury.

Drs. Case and Watson did not opine that there had been an independent, new injury in 1990. Although they stated that both the 1988 injury and the July 1990 incident were contributing causes for claimant's need for treatment, they also stated that the major contributing cause of the need for treatment was the initial December 1988 injury. (Ex. 32-4). We note that this opinion could be interpreted to mean that a material cause of claimant's need for treatment is the July 1990 incident.

We generally give greater weight to the conclusions of a treating physician. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds, 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986). Here, we find no persuasive reason not to defer to claimant's treating physician, Dr. DiPaola, especially given the fact that he treated claimant after the initial 1988 injury and both 1990 incidents. Also, we note that the examining physicians do not opine

that a new injury occurred in 1990, and their statements support Dr. DiPaola's opinion that the major contributing cause of claimant's current need for treatment is the 1988 compensable injury.

Accordingly, because the evidence does not establish that claimant suffered a new compensable injury with Home/Savin's insured, SAIF/Savin, as the carrier against whom claimant has an accepted low back strain, remains responsible for future compensable medical services and disability relating to that condition. ORS 656.308(1).

Compensability -- Aggravation Claim

At hearing, SAIF/Savin contended that claimant had not established a compensable aggravation. Because the Referee assigned responsibility to Home/Savin, he did not address claimant's aggravation claim against SAIF/Savin.

In order to prove a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). A worsened condition is established with evidence of increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Leroy Frank, 43 Van Natta 1950 (1991). In addition, the worsening must be established with medical evidence supported by objective findings. ORS 656.273(3).

Dr. DiPaola noted increased pain, spasm, and decreased range of motion in the lumbar spine following the 1990 incidents. (Exs. 12-3, 36). He concluded that claimant's condition had symptomatically worsened as a result of the 1988 injury. (Exs. 27, 29-3, 37A). In addition, Drs. Case and Watson found that claimant was more disabled than at the time of his closing examination based on his reductions in ranges of motion. (Ex. 32-4). As noted above, they attributed this worsening, in major part, to the 1988 injury.

Following the 1988 injury, claimant was released to work without restrictions and was able to perform his regular work. (Exs. 20, 21). After the 1990 incidents, claimant was restricted to light duty work. (Exs. 26, 36).

We note that the Notice of Closure, claimant's prior award of compensation, did not award any permanent disability. Thus, claimant need not establish that his worsening is more than waxing and waning of symptoms contemplated by the previous permanent disability award. ORS 656.273(8). For that reason, we do not find that the medical reports which discuss claimant's worsening in terms of waxing and waning affect claimant's aggravation claim.

After our review of the record, we conclude that claimant has proven a compensable worsening of his low back condition. Accordingly, SAIF/Savin's denial is set aside and the claim is remanded to SAIF/Savin for further processing.

Attorney Fees

The Referee awarded claimant an assessed attorney fee of $1,000 for services at hearing to be paid by Home/Savin. Because we find SAIF/Savin responsible, this assessed fee is to be paid by SAIF/Savin. Tanya L. Baker, 42 Van Natta 2818 (1990).

The Referee found that compensability was not an issue at hearing. However, Home/Savin's denial had questioned compensability and no .307 order was issued. In addition, although all parties conceded at hearing that claimant has a work related low back condition, SAIF/Savin denied that there was a compensable aggravation. On this record, we find that claimant's right to compensation was at risk at the hearing. Therefore, by virtue of the Board's de novo review authority, compensability remained at risk on review as well. See Dilworth v. Weyerhaeuser Co., 95 Or App 85 (1989). Therefore, claimant's counsel is entitled to an assessed attorney fee for services on review. See Tanya L. Baker, 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 on review is $200, to be paid by SAIF/Savin.

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

ORDER

The Referee's order dated August 27, 1991 is affirmed in part, reversed in part, and modified in part. The Home Insurance Company's denial of claimant's new injury claim is reinstated and upheld. The SAIF Corporation's denial of claimant's aggravation claim on behalf of Savin Northwest is set aside, and the claim is remanded to SAIF for further processing according to law. The Referee's award of an assessed fee of $1,000 for services at hearing is to be paid to claimant's attorney by SAIF/Savin. For services on review, claimant's attorney is awarded an assessed fee of $200, to be paid by the SAIF/Savin. The remainder of the order is affirmed.

In the Matter of the Compensation of
ELENA MEDA, Claimant
WCB Case No. 89-22035
ORDER ON REMAND
Dennis O'Malley, Claimant Attorney
James Dodge (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Meda v. SAIF, 112 Or App 446 (1992). The court reversed our prior order which adopted a Referee's order upholding the SAIF Corporation's denial of claimant's left foot injury claim. Reasoning that we should explain why we had rejected the only direct evidence concerning the cause of claimant's injury, the court has remanded for reconsideration.

FINDINGS OF FACT

Claimant worked a full day picking apples on August 27, 1989. She had no trouble walking and had no problems with her left foot before going to work the next day. (Tr. 17-19). Claimant's son, who resides with her, drove her to work on August 28, 1989. Claimant had no trouble walking from the car to the orchard.

Claimant and her son began working about 7:00 a.m. on August 28. They worked on separate tripod type ladders, picking apples from the same tree. No other workers were in the vicinity; the nearest workers were two or three rows away, approximately 50 feet away. (Tr. 28). Claimant had picked about half a bag of apples. A short time after beginning to work, the son heard some noise to his right, turned, and saw claimant falling from her ladder towards her left. (Tr. 19). The ladder fell with her. The son did not actually see how claimant landed because he was hurrying down from his ladder to go to her. When he got to claimant, she told him that she had hurt her left foot.

The son got the car, drove it into the orchard, and carried her to the car. (Tr. 20). At about 7:30 a.m., as they were driving out of the orchard, they met the employer. (Tr. 21, 27). The son told the employer that: (1) claimant had fallen off of a ladder and sprained her foot; (2) he was taking her home or to a doctor; and (3) he would return to work. (Tr. 21, 27). Claimant thought that she had only sprained her ankle and wanted to go home rather than to the Emergency Room. (Tr. 21).

The son carried claimant from the car to the house because she was unable to walk. (Tr. 21). Thereafter, claimant consumed a glass of tequila and two beers. About 11:00 a.m., claimant's husband and daughter took her to the Emergency Room. Claimant was unable to walk, and her husband carried her to and from the car.

In the Emergency Room, claimant was examined by Dr. Jacobs, M.D., who diagnosed a nondisplaced fracture of the left calcaneous and alcohol intoxication. (Ex. 4). Dr. Jacobs noted marked

swelling and bruising about claimant's left ankle and foot. (Exs. 4, 13). Claimant was referred to Dr. Didelius, orthopedist, who became her treating physician.

Dr. Didelius first treated claimant within hours of her Emergency Room visit. (Ex. 5). Noting that claimant's foot and ankle were tender but that most of the swelling was confined to the hind foot, Dr. Didelius confirmed the diagnosis of a fractured left calcaneous. (Ex. 5). A short-leg plastic cast was applied to claimant's left leg. Claimant was on crutches and required to be nonweight bearing until November 22, 1989. (Ex. 15).

Claimant complained of pain in her left ribs, and a September 8, 1989 x-ray revealed an undisplaced fracture of the ninth rib. (Exs. 5, 6).

Following the son's report of the accident, the employer went to the area where claimant and her son had been working. The employer did not find any apples in the bin or on the ground. (Tr. 28). The employer filed an 801 form in which he noted that the injury occurred during the course of employment. (Ex. 1).

SAIF formally accepted the claim on September 27, 1989. (Ex. 9). On October 9, 1989, within 60 days of the employer's knowledge of the injury, SAIF rescinded its acceptance. (Ex. 12). Claimant requested a hearing.

CONCLUSIONS OF LAW

The Referee upheld SAIF's denial of claimant's left foot injury claim. In reaching this conclusion, the Referee found that claimant was not a reliable witness. The Referee also found no basis to question the credibility of claimant's son, her daughter, or the employer. On review, we affirmed and adopted the Referee's order.

The court reasoned that the Referee had accepted many aspects of the son's testimony, including his testimony that he and claimant had gone to the orchard to pick apples, had left at 7:30 a.m., and had reported the accident to the employer on the way home. Given the Referee's finding that there was no basis to question the son's credibility, a finding that we adopted, the court has concluded that we should explain why we rejected the son's testimony that claimant fell while picking apples. Consequently, the court has reversed and remanded for reconsideration.

To establish the compensability of an injury claim for her left foot and rib fractures, claimant has the burden of proving that her work activity was a material contributing cause of her disability or need for medical services. See Harris v. Albertson's, Inc., 65 Or App 254, 256-57 (1983). "Material contributing cause" means a substantial cause, but not necessarily the sole cause or even the most significant cause. See Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987): Lobato v. SAIF, 75 Or App 488, 492 (1985).

Claimant's son testified that claimant had no problems with her left foot before beginning work on August 28, 1989. He further testified that while both he and claimant were on ladders picking apples from the same tree, he heard a noise to his right, turned, and saw claimant fall from her ladder towards her left. When he went to claimant she told him that her left foot was injured. The son reported that claimant was unable to walk after the fall.

The accident was reported immediately to the employer who investigated the area within minutes and initially reported that the accident occurred within the course of employment. (Ex. 1). At hearing, the employer testified that he subsequently asked to have the claim investigated. (Tr. 26). Evidently, the employer requested this investigation because: (1) there were no witnesses to the accident other than claimant's son; and (2) the employer did not find any apples in the bin or on the ground where claimant and her son were working. (Tr. 28). Claimant does not contend that there were witnesses other than her son. Also, we do not consider the apparent discrepancy concerning the number of apples picked in the area of the accident noteworthy, particularly since the employer did not indicate whether any partially filled "bags" were in the area. The employer seemed to indicate only that there were no apples in the bin or loose on the ground.

Dr. Jacobs, M.D., treated claimant in the Emergency Room around 11:00 a.m. on August 28, 1989. Claimant had consumed alcohol prior to going to the Emergency Room and she was intoxicated by the time she got there. Although Dr. Jacobs acknowledged that a fall from a ladder could cause claimant's injuries, he questioned the circumstances surrounding the accident based on claimant's intoxication and the amount of swelling. (Exs. 4, 13). Initially, Dr. Jacobs noted that the amount of swelling suggested that the injury occurred more than four hours before she came to the Emergency Room. (Ex. 4). He later opined that the injury had possibly occurred the night before. (Ex. 13).

Dr. Didelius, treating orthopedist, examined claimant only a few hours after she was examined by Dr. Jacobs. (Exs. 4, 5). Dr. Didelius noted no unusual amount of swelling. He noted that the "foot and ankle are certainly tender, but most of the swelling is confined to the hind foot." (Ex. 5). Also, Dr. Didelius did not question that the injury was caused by a fall from a ladder that morning.

We find Dr. Jacobs' comments to be speculative, especially given the fact that Dr. Didelius, claimant's treating orthopedist, noted no inordinate amount of swelling. In addition, other than Dr. Jacobs' speculation, there is no evidence that the injury occurred off the job. Claimant was able to walk from the car to the orchard that morning before beginning to work. However, after she fell and broke a bone in her foot, she was unable to walk and had to be carried.

On reconsideration, we find that claimant has established that she fell from a ladder while working and that this fall was a material contributing cause of her disability and need for medical treatment. Accordingly, we reverse the Referee's order dated May 22, 1990. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing in accordance with law.

Inasmuch as claimant has finally prevailed over a denial of compensability following remand, she is entitled to an attorney fee for services rendered before every prior forum. ORS 656.388(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 before every prior forum is $4,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, and the value of the interest involved.

IT IS SO ORDERED.

In the Matter of the Compensation of
OLEGARIO SANCHEZ-TORRES, Claimant
WCB Case No. 90-21375
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Charles A. Ringo, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of Referee T. LaVere Johnson's order which: (1) found that claimant's back injury claim was prematurely closed; and (2) as a result of the premature closure finding, declined to consider the extent of claimant's permanent disability or an offset request. On review, the issues are premature closure and, alternatively, extent of permanent disability and offset.

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

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 June 11, 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.

After conducting our review, we conclude that, at the time of the June 11, 1990 Determination Order, there was a reasonable expectation of improvement in claimant's condition from medical treatment or the passage of time. We base our conclusion on the following reasoning.

The opinion of Dr. Ruby, claimant's treating chiropractor, is the only medical opinion that directly addresses when claimant became medically stationary, albeit he does so in a letter prepared by claimant's attorney. Dr. Ruby states that claimant became medically stationary on June 15, 1990, and he adhered to this opinion on cross-examination during his deposition. (Ex. 21; Ex. 22-22 to -23). Dr. Ruby explained in his deposition that by June 1990, claimant had improved 80-90 percent (Ex. 22-17), and that he was then medically stationary with respect to the multiple remissions and exacerbations he had experienced in preceding months. (Ex. 22-22; see also, Ex. 22-11, 22-15 to -16).

On the other hand, Dr. Morris, an orthopedist who conducted an independent medical examination on November 30, 1989, never stated specifically that claimant was medically stationary. Indeed, although he responded to the insurer's question on January 5, 1990 stating that claimant had no impairment and no residual disability (Ex. 15), he also indicated in the November 1989 examination that "an MRI is probably indicated," and that he would recommend sending claimant to physical therapy. (Ex. 14). We find that Dr. Morris' recommendation for further treatment in November 1989 is inconsistent with a medically stationary status at that time, and there is no subsequent evaluation by Dr. Morris of whether claimant had become medically stationary at a later time. Therefore, we do not rely on Dr. Morris' opinion to determine claimant's medically stationary date, but we rely instead on Dr. Ruby's opinion.

Because we find that the claim was closed prematurely, we do not address the issues of extent of permanent disability or offset.

The insurer argues on review that even if the claim was prematurely closed, claimant is not entitled to additional temporary disability benefits because he refused offered employment. We find no evidence that the insurer raised this issue before the Referee. Therefore, we decline to address it on review. See Helen S. Long, 44 Van Natta 119 (1992); Lela K. Mead, 44 Van Natta 535, 536 (1992).

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) 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 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 August 29, 1991 is affirmed. For services rendered on review, claimant's attorney is awarded $500, to be paid by the insurer.

In the Matter of the Compensation of
REBECCA J. ZUMWALT, Claimant
WCB Case No. 91-05304
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Lester Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Nichols' order that upheld the SAIF Corporation's partial denial of claimant's claim for cubital tunnel, thoracic outlet and brachial plexus 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

The Referee found that claimant failed to prove that her cubital tunnel, thoracic outlet and/or brachial plexus conditions are work-related under either the material or major cause standard. We reach the same result, based on the following analysis.

It is undisputed that claimant's chronic neck and right upper extremity problems preexisted her January 8, 1990 compensable cervical strain injury. However, claimant argues that inasmuch as her preexisting conditions are compensably related to a prior work incident, she need only prove that the January 1990 compensable injury is a material cause of the conditions currently claimed. Alternatively, claimant contends that she has carried her burden even if the major cause standard applies. We disagree with both contentions.

Due to the passage of time and the number of potential causes for claimant's cubital tunnel, thoracic outlet and/or brachial plexus conditions, the causation issue is a complex medical question which must be resolved by expert 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). Claimant testified that she suffered a back and right shoulder strain injury at work in 1980 or 1981. (Tr. 6-8). Drs. Wilson and Gerstner reported consistent histories. (Exs. 19 & 34-1). Gerstner noted claimant's statement that she had "filed a report regarding her back injury but pursued [it] no further because the back improved." (Ex. 35-1). On this record, we are unable to conclude that claimant had a prior compensable back condition. Moreover, no medical opinion relates claimant's current complaints to a 1980 or 1981 incident. In the absence of such evidence, we conclude that claimant has not established that her current complaints are compensably related to a work injury which occurred prior to the January 8, 1990 fall. See Harris v. Albertson's, Inc., 65 Or App 254 (1983); Uris v. Compensation Department, supra.

Claimant argues that she need only prove that her compensable injury was a material cause of the conditions currently claimed, because the January 8, 1990 work injury occurred before the 1990 amendments to Workers' Compensation Law became effective. We conclude that claimant's initial burden requires establishing work as a material cause of her injury under amended ORS 656.005(7)(a).

We have previously held that the legislature intended the 1990 amendments to the Workers' Compensation Act to apply retroactively, i.e., regardless of the date of injury, except as provided in Section 54(2) of the Act or where such application would produce absurd or unjust results. Ida M. Walker, 43 Van Natta 1402 (1991). Here, claimant requested a hearing after May 1, 1990 and the hearing convened after July 1, 1990. Therefore, the "litigation savings clause" contained in Section 54(2) of the Act does not apply. In addition, the matter at issue here is not subject to a special exception to the Act's general applicability provision. See e.g. Section 54(3). Moreover, application of the 1990 amendments will not produce an absurd or unjust result inconsistent with the purposes and policies of the Workers' Compensation Law. See Ida M. Walker, supra. Accordingly, we analyze this matter under the Act as amended, effective July 1, 1990.

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).

In this case, there is no doubt that claimant suffered a compensable cervical strain injury on January 8, 1990 and SAIF accepted her claim for that injury. (Ex. 18). SAIF partially denied the conditions diagnosed as cubital tunnel, thoracic outlet and/or brachial plexus neuritis. (Ex. 33). Because it is undisputed that Dr. Wilson suspected brachial plexus neuritis and right cubital tunnel syndrome by January 5, 1990, three days before the January 8, 1990 incident, (see Ex. 6), we find that these conditions preexisted claimant's compensable injury. Moreover, there is evidence that these preexisting conditions combined with the compensable 1990 cervical injury to cause or prolong claimant's disability or need for treatment for her right upper extremity. (See exs. 11, 15-1, 21). Therefore, under ORS 656.005(7)(a), we first consider whether claimant's January 8, 1990 injury is a material cause of her current cubital tunnel, thoracic outlet and/or brachial plexus neuritis conditions. If it is, we next consider whether the compensable injury is the major cause of claimant's current need for treatment for these conditions. See ORS 656.005(7)(a) & (B); Bahman M. Nazari, supra; Mark N. Wiedle, supra.

Dr. Wilson, who examined claimant on numerous occasions, was aware of claimant's 10-year history of mild right shoulder and neck pain and suspected cubital tunnel and brachial plexus neuritis prior to the January 1990 incident. By October 5, 1990, Wilson also suspected thoracic outlet syndrome. (Ex. 23; see ex. 25-2). Although Wilson's reports support the compensability of claimant's January 1990 cervical problems, they do not address the causation of claimant's cubital tunnel, thoracic outlet and/or brachial plexus neuritis conditions.

The only medical evidence supporting claimant's current claim is the opinion of Dr. Gerstner. Gerstner stated: "Since the patient was asymptomatic prior to the injury, it would therefore be my opinion that the accident of January 9, 1990 was the major cause in the change in her underlying condition." (Ex. 36). Because the record indicates that claimant was not asymptomatic prior to the January 1990 incident and Gerstner's opinion is based on that materially inaccurate history, his opinion regarding causation is not persuasive. Therefore, we do not rely on it. See Somers v. SAIF, 77 Or App 259 (1986).

In the absence of persuasive medical evidence relating the conditions currently claimed to the compensable injury, we conclude that claimant has not carried her burden of proving that her work injury was a material cause of those conditions. See ORS 656.005(7)(a); Mark N. Wiedle, supra; Uris v. Compensation Department, supra. Accordingly, we also conclude that claimant has not proven that her need for treatment, which may result from preexisting conditions combined with the compensable

injury, is caused in major part by the compensable injury. See ORS 656.005(7)(a)(B); Bahman M. Nazari, supra. Therefore, the current claim is not compensable.

ORDER

The Referee's order dated August 26, 1991 is affirmed.

In the Matter of the Compensation of
TRUDY G. LANGSTON, Claimant
WCB Case No. 89-22732
ORDER ON REMAND
Westmoreland & Shebley, Claimant Attorneys
Julene M. Quinn (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Langston, 112 Or App 441 (1992). The court reversed our prior order, Troy G. Langston, 43 Van Natta 549 (1991), that set aside SAIF's denial of claimant's occupational disease claim for dermatitis and respiratory conditions. The court determined that it was not apparent that we had considered ORS 656.266 in reaching our conclusion that the claim was compensable. Reasoning that it was necessary for us to consider the application of ORS 656.266 to the facts of this case, the court remanded for reconsideration.

After conducting our reconsideration, we republish our prior order with the following supplementation.

A worker cannot carry the burden of proving the compensability of a claim merely by disproving other possible explanations of how the injury or occupational disease occurred. ORS 656.266. Our conclusion that claimant's occupational disease claim is compensable has not been based on the mere disproving of other possible explanations for the causation of claimant's dermatitis and respiratory conditions. Rather our decision is based on the persuasive and well-reasoned opinion of Dr. Green, claimant's treating allergist, who concluded that claimant's exposure to contaminants in the work place was the "major single cause" of her dermatological and respiratory problems.

In reaching this conclusion, we recognize that Dr. Green ruled out a number of potential non-workplace causes. Nevertheless, in addition to the rejection of these other potential explanations for claimant's conditions, Dr. Green persuasively concluded that the conditions were work-related. This opinion was primarily based on the nature of claimant's symptoms and their correlation with claimant's work schedule. Considering Dr. Green's specialized expertise as an allergist and his advantage as claimant's treating physician, we defer to this opinion.

Inasmuch as claimant has finally prevailed after remand, she is entitled to an attorney fee for services rendered before all prior forums. ORS 656.388(1). Claimant has already been awarded carrier-paid attorney fees for services at the hearing and on review. Consequently, in addition to those awards, we grant claimant an attorney fee for services performed at the Court of Appeals.

After considering the factors set forth in OAR 438-15-101(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services before the Court of Appeals is $2,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as evidenced by claimant's respondent's brief before the court), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney might go uncompensated.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our March 14, 1991 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LILLIE M. SIMS, Claimant
WCB Case No. 91-00706
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Thye's order which upheld the self-insured employer's denial of claimant's carpal tunnel occupational disease claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings" with the exception of his "Ultimate Findings."

CONCLUSIONS OF LAW AND OPINION

The Referee found that the evidence was insufficient to find that claimant has bilateral carpal tunnel syndrome. Based upon that finding, the Referee uphald the employer's denial of her occupational disease claim.

To establish compensability of her occupational disease claim, claimant must prove by a preponderance of the evidence that a series of traumatic events or occurrences at work were the major contributing cause of her condition requiring medical services or resulting in physical disability. This must be established by medical evidence supported by objective findings. ORS 656.802(1)(c)(2).

The medical record indicates that claimant's condition has not been definitely diagnosed by either her treating physician or by the other medical examiners in the record. The lack of a definitive diagnosis does not per se defeat the claim. See Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988). It is not a necessary predicate to compensability that the medical experts know the exact mechanism of the disease. Robinson v. SAIF, 78 Or App 581 (1986). However, the causation issue, as opposed to the question of diagnosis, must be resolved. Stewart E. Myers, 41 Van Natta 1985 (1989). We find that this issue is sufficiently medically complex to require expert medical opinion. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

The only doctors who address the issue of causation are Dr. Buehler, Dr. Nolan and Dr. Balkovich. All of these physicians are plastic, reconstructive and hand surgeons. Claimant was referred to Dr. Buehler by Dr. Smith, the emergency room physician who first examined claimant for her condition. Dr. Balkovich was claimant's treating physician at the time of hearing. Dr. Nolan was an independent medical examiner.

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. Balkovich.

Seventy percent of Dr. Balkovich's practice is comprised of hand surgery. (Ex. 19, p.5). Dr. Balkovich thoroughly and accurately described how claimant's repetitive and continuous wrist and hand work contributed to her condition. (Ex. 19, pp. 8-10). Dr. Balkovich explained the clinical tests he performed which were, in part, the basis of his opinion. In addition, based upon claimant's work history, the description of her job and her symptoms, Dr. Balkovich testified that claimant's work is the major contributing cause of her symptoms.

The Referee discounted Dr. Balkovich's opinion on the basis that the clinical tests performed by Dr. Balkovich were dependent upon claimant's subjective response and not independently verifiable. We disagree.

A claimant may satisfy the "objective findings" requirement of ORS 656.005(7)(a) if she offers evidence that a physician has examined her and determined that she 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, ORS 656.005(19), or on the worker's description of the pain that she is experiencing, as long as the physician indicates that the worker in fact is experiencing symptoms and does not merely recite the claimant's complaints of pain. Suzanne Robertson, supra.

In this case, Dr. Balkovich's report noted that "median nerve pressure bi-laterally led to very rapid production of symptoms in her hands. Flexing her wrists led to reproduction of the symptoms as well . . . After applying pressure to her wrists this was followed by discomfort in that area." Under the circustmances, we conclude that Dr. Balkovich's notes constitute objective findings defined by ORS 656.005. See Exhibit 16A. Additionally, Dr. Blakovich clearly indicated that the claimant was experiencing the symptoms for which she was seeking treatment. (Ex. 19, pp. 7, 8). Although his diagnosis of carpal tunnel "is not a firm diagnosis," Dr. Balkovich found that claimant suffered from pain, numbness, and a sensation of swelling. (Ex. 19, pp. 7, 8, 15). He prescribed the use of splints and recommended conservative treatment with observation before prescribing more aggressive measures (i.e., cotisone injections and surgery). (Exs. 18; 19, pp. 7, 22, 23). Dr. Balkovich's persuasive opinion therefore satisfies "objective findings" under Suzanne Robertson. We thus conclude that claimant has established her claim with medical evidence supported by objective findings.

Moreover, we do not find that claimant reported an inconsistent history as to the onset of her symptoms to Dr. Balkovich or any of the other medical providers in the record. A co-worker testified that claimant had complained of soreness on more than one occasion before November 20, 1990. (Tr. 54, 56, 60, 61). The co-worker testifies that claimant had iced her hand at work prior to November 1990. (Tr. 58, 59). This history is consistent with chart notes of claimant's history, such as "increasing pain in her right hand" (Ex. 4), "gradually developed pain" (Ex. 8-1), and "developed pain in both hands while doing cracker loading." The report also noted that, "this got to the point in late November where she could not tolerate the pain in her hands anymore" (Ex. 11A), and "the pains in her hands have been worsening over the last seven months" (Ex. 16A). Under the circumstances, we do not find that a gradual, incrasing onset of pain is inconsistent with her reports of "swelling" (Exs. 1, 2, 3), "cramping" (Exs. 1, 2, 9), "stinging" (Ex. 3), "tingling" (Ex. 9-1), "hurting real bad" (Ex. 1), and " a lot of pain" (Ex. 9-1) on November 20, 1990.

We are persuaded that Dr. Balkovich's opinion was based upon an accurate and reliable history as supplied by claimant. We, therefore, find that the record in this case satisfies claimant's burden of proof. Accordingly, we set aside the employer's denial of claimant's occupational disease claim.

For prevailing on the issue of compensability, claimant's counsel is entitled to an assessed 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 assessed fee for claimant's counsel's services at hearing and on Board review is $3,000, 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 and appellant's brief on review), the complexity of the issue and the value of the interest concerned.

ORDER

The Referee's order dated June 17, 1991 is reversed. The self-insured employer's denial is set aside and claimant's claim is remanded to the employer for processing according to law. For services at hearing and on review concerning the compensability issue, claimant's counsel is awarded an assessed fee of $3,000, to be paid by the employer.

In the Matter of the Compensation of
JACK J. FORD, JR., Claimant
WCB Case Nos. 90-19806 & 90-11658
ORDER ON RECONSIDERATION
Olson, et al., Claimant Attorneys
Robert Jackson (Saif), Defense Attorney

Claimant requests reconsideration of our June 29, 1992 Order on Review. On reconsideration, claimant asserts that he is entitled to an assessed attorney fee pursuant to ORS 656.386(1) for prevailing on an aggravation denial.

Because claimant did not prevail finally on the aggravation issue, we decline to award an assessed attorney fee pursuant to ORS 656.386(1). At hearing, claimant argued that his claim had been prematurely closed. As an alternative issue, he challenged SAIF's aggravation denial. Claimant did not challenge the aggravation denial on the merits, but asserted that it was prematurely issued. In his order, the Referee found that SAIF's aggravation denial was neither premature nor unreasonable since claimant was seeking additional curative medical treatment for an alleged worsened condition. Thus, the Referee found that the sole basis for the failure of claimant's aggravation claim was the fact that claimant prevailed instead in establishing that his claim had been prematurely closed.

By definition, an aggravation is a worsened condition occurring after claim closure and can only become an issue once a valid claim closure has been accomplished. ORS 656.273; Brian C. Roll, 40 Van Natta 2046 (1988). Here, by virtue of the Referee's decision that the claim had been prematurely closed, the aggravation issue became moot since there could be no aggravation while the claim was open. Brian C. Roll, supra; Myrel M. Henning, 40 Van Natta 1585, 1587 (1988). As a consequence, the Referee did not need to address the moot aggravation issue in his order. It was equally unnecessary to "set aside" the aggravation denial. As we find that claimant did not prevail on his aggravation claim, we continue to conclude that he is not entitled to an assessed attorney fee pursuant to ORS 656.386(1).

Claimant argues that our holding in this case is contrary to our decision in Carol J. Knapp, 41 Van Natta 855 (1989), in which we held that an aggravation denial was "null" and indicated that claimant's counsel would have been entitled to an assessed fee had he filed a statement of services. However, in Knapp, the sole issue at hearing was the aggravation claim. In the present case, claimant presented alternative issues and could prevail and receive an attorney fee for only one of those issues. Claimant prevailed on the premature closure issue and was awarded a fee out of compensation.

Accordingly, our June 29, 1992 Order on Review is withdrawn. As supplemented and clarified herein, we republish our June 29, 1992 Order on Review 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
CHESTER L. SCHULZE, Claimant
WCB Case No. 90-21961
ORDER ON REVIEW
Flaxel, et al., Claimant Attorneys
Foss, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of those portions of Referee Emerson's order that set aside its denials of claimant's left carpal tunnel syndrome and medical services claim for left carpal tunnel surgery. Claimant cross-requests review contending that the November 23, 1990 Determination Order should be set aside as premature. On review, the issues are compensability, medical services and premature closure. We affirm in part and vacate in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the Referee's conclusions and reasoning concerning the compensability of claimant's left carpal tunnel syndrome.

Medical Services

The Referee concluded that the proposed left carpal tunnel surgery was reasonable and necessary and therefore set aside the insurer's denial. We find that the Referee lacked jurisdiction over the insurer's denial concerning the proposed surgery. We also conclude that the insurer's denial is null and void as a matter of law.

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 2642 (1991). ORS 656.327 provides a procedure for the resolution of disputes between the carrier and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services." Furthermore, an insurer may not issue a denial and a claimant may not request a hearing on a dispute over medical services that is subject to the Director's jurisdiction. ORS 656.327(1)(c). Stanley Meyers, supra.

Moreover, 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). Thus, in a situation such as this, the insurer has but two alternatives consistent with law: either pay the disputed medical billings or promptly request Director review under ORS 656.327. Stanley Meyers, supra.

Inasmuch as the insurer's denial concerning the proposed surgery was subject to the Director's jurisdiction, the denial was null and void and the request for hearing was premature. Accordingly, we vacate the Referee's order and dismiss claimant's hearing request as to that issue. Id. If it has not already done so, the insurer should request Director review of this medical services dispute without further delay.

Premature Closure

Claimant contends that inasmuch as the Referee set aside the insurer's denial of his left carpal tunnel syndrome, the November 23, 1990 Determination Order should be set aside as premature.

However, any party who objects to a Determination Order must first request reconsideration by the Appellate Unit of the Department of Insurance and Finance. ORS 656.268(5); Lorna D. Hildebrand, 43 Van Natta 2721 (1991). Here, the record does not establish that claimant requested reconsideration by the Director of the November 23, 1990 Determination Order. Therefore, we are without jurisdiction over the premature closure issue and have no authority to set aside the Determination Order as premature. Charlene J. Erspamer, 44 Van Natta 1214 (1992); Diane B. Allen, 44 Van Natta 1210 (1992). Accordingly, the issue of premature closure is not properly before us at this time.

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 of claimant's left carpal tunnel syndrome issue is $750, 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 is vacated in part and affirmed in part. That portion of the Referee's order that set aside the insurer's denial of surgery on the basis of reasonableness and necessity is vacated. The remainder of the order is affirmed. For services on review concerning the compensability issue, claimant's counsel is awarded an assessed attorney fee of $750, payable by the insurer.

July 21, 1992 Cite as 44 Van Natta 1495 (1992)

In the Matter of the Compensation of
BOBBY BRADBURRY, Claimant
Own Motion No. 92-0162M
OWN MOTION ORDER
Pozzi, et al., Claimant Attorneys
David Fowler (Saif), Defense Attorney

The SAIF Corporation submitted claimant's request for temporary disability compensation for his compensable stress claim. Claimant's aggravation rights on that claim expired on December 24, 1990. SAIF accepted the compensability of claimant's need for hospitalization for chest pain under the above captioned claim.

Claimant had filed a new injury claim on August 2, 1991 which SAIF had denied. Claimant requested a hearing with the Hearings Division and the Board postponed action on claimant's own motion request on April 15, 1992. (WCB Case Nos. 91-14915, 91-13626 and 91-15052).

On July 10, 1992 the remaining pending hearings were settled by a Stipulation and Order and the requests for hearings were dismissed. (WCB Case Nos. 91-14915, 91-13626 and 91-15052) WCB Case No. 91-13626 was not related to the own motion issue.

Accordingly, we may authorize the reopening of claimant's claim to provide temporary total disability compensation beginning the date he was hospitalized for his stress claim. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-12-055.

An injured worker is not entitled to receive any more than the statutory sum of benefits for a single period of temporary disability resulting from multiple disabling injuries. See Fischer v. SAIF, 76 Or App 656, 661 (1985); Petshow v. Portland Bottling Co., 62 Or App 614 (1983), rev den 296 Or 350 (1984). Therefore, if any concurrent temporary disability is due claimant as a result of this order, the benefits shall be paid in accordance with OAR 436-60-020(7) and (8).

IT IS SO ORDERED.

July 21, 1992 Cite as 44 Van Natta 1495 (1992)

In the Matter of the Compensation of
TERRY A. CROY, Claimant
WCB Case Nos. 91-09788 & 90-21735
ORDER ON REVIEW
Dean Heiling, Claimant Attorney
James Dodge (Saif), Defense Attorney
Terrall & Associates, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Lipton's order that upheld Liberty Northwest's denials of claimant's aggravation claim for a low back condition. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" as supplemented. Claimant filed requests for hearing on December 5, 1990 and July 22, 1991; a consolidated hearing was held on October 22, 1991.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's reasonings and conclusion that claimant failed to demonstrate any relationship between his May 1990 pain flare-up and the compensable May 1986 injury, with the following comment.

As a preliminary matter, claimant argues that because his condition symptomatically worsened in May 1990, prior to the effective date of SB 1197, "objective findings" of a worsened condition are not required. The date that the worsening occurred is not controlling. Rather, it is the date that the hearing was convened. See Or Laws 1990 (Special Session), ch. 2, sect. 54(2). Because the hearing in this case was convened and held after July 1, 1990, the Referee properly analyzed this matter under the Workers' Compensation Law effective July 1, 1990. Ida M. Walker, 43 Van Natta 1402 (1991).

Claimant further argues that he has proven the worsening of his condition by "objective findings." The Referee did not find otherwise, and neither do we. Instead, the Referee found that claimant has failed to establish that his recurrent backaches are related to his compensable strain, rather than to his hyperlordosis (sway-back) condition. We agree.

ORS 656.273(1) provides, in pertinent part, that aggravation claims are claims for "worsened conditions resulting from the original injury." A worsening of a condition that is unrelated to a compensable condition cannot be the basis of an aggravation claim. See Argonaut Ins. Co. v. Rush, 98 Or App 739 (1989).

Thus, although claimant has established the worsening of his low back condition by objective findings, he has not established that his recurrent backaches result from the original injury. See Argonaut Ins. Co. v. Rush, supra.

ORDER

The Referee's order dated November 8, 1991 is affirmed.

In the Matter of the Compensation of
RONDA J. STYLES, Claimant
WCB Case No. 90-20140
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney
Edward C. Olson, Defense Attorney

Reviewed by Board Members Kinsley and Brazeau.

Claimant requests review of Referee Neal's order which upheld: (1) Giesy, Greer & Gunn's denial of claimant's aggravation claim for fibromyalgia and rheumatoid arthritis conditions; (2) Giesy's denial of claimant's occupational disease claim for the same conditions; and (3) Liberty Northwest Insurance Corporation's denial of claimant's occupational disease claim for the same conditions. On review, the issues are aggravation, compensability and responsibility. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. Claimant returned to her regular work in November 1988. She sought treatment from Dr. Turnbull, chiropractor, in June 1989. (Ex. 19).

FINDINGS OF ULTIMATE FACT

We adopt paragraph (1) of the Referee's ultimate findings of fact and supplement as follows.

Claimant's work activities involving a series of repetitive traumatic events were the major contributing cause of her fibromyalgia and a pathological worsening of her preexisting rheumatoid arthritis conditions that resulted in medical treatment. This pathological worsening is established by medical evidence supported by objective findings.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

In deciding this matter, the Referee applied the Workers' Compensation 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 too analyze this matter under the Workers' Compensation Law as amended, effective July 1, 1990. See Or Laws 1990 (Special Session), ch 2, § 54; Ida M. Walker, 43 Van Natta 1402 (1991).

Compensability

Relationship of 1986 Claim

Claimant has been diagnosed with two separate conditions, fibromyalgia (also referred to as fibrositis and myofascial syndrome) and rheumatoid arthritis. Claimant contends that both conditions are compensable consequences of the accepted 1986 lumbar strain. Alternatively, claimant contends that both conditions are new occupational diseases.

As a preliminary matter, under either theory, the existence of a disease or the worsening of a preexisting disease must be established by medical evidence supported by objective findings. ORS 656.273(1) and 656.802(2). We adopt paragraph three, page four, of the Referee's opinion in which she finds that claimant's fibromyalgia and rheumatoid arthritis were established by medical evidence supported by objective findings.

In order to establish the compensability of her fibromyalgia as a consequential condition of her accepted injury, claimant must prove that her compensable injury was the major contributing cause of that condition. ORS 656.005(7)(a)(A).

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 the well-reasoned explanation of the development of fibromyalgia by Dr. Feinberg, claimant's treating chiropractor, and Dr. Schoepflin, her treating rheumatologist, more persuasive than that of the independent medical examiners. Furthermore, the causation of claimant's rheumatoid arthritis 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). Accordingly, we defer to Dr. Schoepflin, a Board-certified rheumatologist, on this issue, as did Drs. Jessen and Gritzka in their independent medical examination. Furthermore, when there is a dispute between medical experts, the greater weight will be given to those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 262 (1986); See Hammons v. Perini Corp., 43 Or App 299, 302 (1979). For this reason, we are not persuaded by the conclusory opinion of Dr. Mayhall, orthopedist, who also performed an independent medical examination.

Dr. Feinberg opined that claimant's fibromyalgia had developed gradually as a result of the 1986 injury plus repetitive work activities performed while both insurers were on the risk. He also opined that the fibromyalgia was caused and worsened in major part by the 1986 injury and claimant's ongoing work exposure. Dr. Schoepflin concurred. Neither doctor offered an opinion as to the relative contributions of the injury and the work exposure. Consequently, we conclude that there is insufficient evidence that the 1986 injury, in and of itself, was the major contributing cause of claimant's consequential fibromyalgia condition. ORS 656.005(7)(a)(A).

With regard to claimant's rheumatoid arthritis, Dr. Schoepflin opined that this condition was a preexisting condition that was temporarily aggravated by the injury and her ongoing work. Because was find that the compensable injury combined with a preexisting condition to cause disability and need for treatment, we analyze this condition under ORS 656.007(a)(B), which requires claimant to establish that the compensable injury is and remains the major contributing cause of the disability or need for treatment stemming from the resultant condition. Here, there is no medical opinion to establish that the compensable injury is and remains the major contributing cause of claimant's disability or need for treatment. Thus, claimant fails her burden here as well.

Accordingly, we find that, although the fibromyalgia and rheumatoid arthritis conditions have some relation to the 1986 injury, the injury, in and of itself, is not the major contributing cause of claimant's fibromyalgia and rheumatoid arthritis conditions and her current disability or need for treatment. ORS 656.005(7)(a) and (b).

Occupational Disease

Because the onset of claimant's fibromyalgia and rheumatoid arthritis symptoms was gradual, rather than sudden, and because the medical evidence relates both conditions to repetitive work activities, we proceed to analyze these claims as new occupational diseases. See ORS 656.802(1)(c).

As noted above, claimant has been diagnosed with fibromyalgia, which allegedly was initially caused by her work exposure, and rheumatoid arthritis, a preexisting condition that allegedly worsened due to work exposure. To establish the compensability of her occupational disease claims, claimant bears the burden of proving by a preponderance of the evidence that her work exposure, in the form of a series of traumatic events or occurrences, was the major contributing cause of the onset of her fibromyalgia condition and the worsening of her preexisting rheumatoid arthritis condition, resulting in disability or need for medical treatment. ORS 656.802(1)(c) and (2). A worsening of symptoms alone is not sufficient, unless the medical evidence supports the conclusion that the manifested symptoms are the disease. Georgia Pacific v. Warren, 103 Or App 275, 278 (1990). However, the underlying condition need not permanently worsen to establish compensability. Rather, a temporary worsening is sufficient. Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979); see also Wheeler v. Boise Cascade, 298 Or 452, 457 (1985). Here, the Referee concluded that claimant had failed to meet her burden of proof. We disagree.

Dr. Feinberg stated that claimant had developed a fibromyalgic (or myofascial) syndrome involving the musculature of the pelvis and the upper dorsal area from the many months that claimant worked in pain after the 1986 injury. He explained the mechanism of the development of claimant's fibromyalgia as the response to the prolonged muscular contraction in the pelvis and low back muscles that compromises the function of the muscle and, in time, produces the degenerative changes which constitute the fibromyalgic syndrome. Furthermore, he stated that the fibromyalgia was a response to the residuals of the 1986 injury and was not the result of claimant's systemic rheumatoid arthritis. He opined that the fibromyalgia was caused and worsened in major part by the 1986 industrial injury and claimant's ongoing work exposure, which consisted of standing, bending and twisting. (Ex. 56). Dr. Schoepflin concurred. (Ex. 57).

We accordingly conclude that claimant has met her burden of proving that work activities, combined with her 1986 injury, caused her fibromyalgia.

With regard to claimant's rheumatoid arthritis, Dr. Schoepflin opined that claimant's work did not cause it, but that the 1986 injury plus her work temporarily aggravated her underlying rheumatic condition and rendered it symptomatic, particularly in her sacroiliac joints. (Exs. 44 and 57). In the context of his opinion, we interpret Dr. Schoepflin's reference to an "aggravation of the underlying condition" to mean a pathological worsening of the underlying condition. (Ex. 44).

Accordingly, we conclude that claimant has also met her burden of proving that her work activities, combined with her 1986 injury, caused a worsening of her preexisting rheumatoid arthritis condition.

Responsibility

The last injurious exposure rule governs the initial assignment of responsibility for conditions arising from an occupational disease which have not been previously accepted. See Fred A. Nutter, 44 Van Natta 854 (1992). The last injurious exposure rule provides that where a claimant proves that an occupational disease is caused by work conditions that existed when 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, Giesy, Greer & Gunn was on the risk only until September 30, 1987. Claimant continued to work with the same employer at the same job until August 8, 1990, which required standing on cement floors and stocking shelves. In addition, she was first treated for her conditions in November 1989, when Liberty Northwest, the second insurer, was on the risk. Consequently, we initially assign responsibility for the occupational disease claims to Liberty Northwest, the carrier on the risk during the last employment providing potentially causal conditions. See Boise Cascade Corp. v. Starbuck, supra; Meyer v. SAIF, supra. Furthermore, Liberty Northwest has not shown that employment conditions while Giesy, Greer & Gunn was on the risk were the sole cause of the diseases, or that it was impossible for conditions while Liberty Northwest was on the risk to have caused the diseases. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374, on recon 73 Or App 223, rev den 299 Or 203 (1985). Accordingly, we find that responsibility for the fibromyalgia and rheumatoid arthritis conditions remains with Liberty Northwest.

Attorney Fees

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 is $3,200, to be paid by Liberty Northwest. In reaching this conclusion, we have particularly considered the time devoted to the case, as represented by 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 February 6, 1991 is affirmed in part and reversed in part. Liberty Northwest Insurance Corporation's October 19, 1990 denial is set aside and the claim is remanded to Liberty Northwest 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 fee of $3,200, to be paid by Liberty Northwest.

In the Matter of the Compensation of
DALE P. BALLOU, Claimant
WCB Case No. 90-21265
ORDER ON RECONSIDERATION
William H. Skalak, Claimant Attorney
Susan Ebner (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our June 4, 1992 Order on Review that affirmed a Referee's order which set aside its partial denials of claimant's current left hip avascular necrosis and femoral head condition. Contending that we did not intend to find it responsible for claimant's underlying avascular necrosis disease, SAIF asks that we uphold those portions of its denials which denied claimant's underlying aseptic/avascular necrosis condition.

We withdraw our June 4, 1992 order for reconsideration. After consideration of SAIF's motion and review of the record, we continue to find that claimant's December 1988 compensable injury is the major contributing cause of his current disability and need for medical treatment for his avascular necrosis and femoral head conditions.

SAIF's argument is premised on the theory that claimant's underlying aseptic/avascular necrosis condition is separate and distinct from the "resultant" condition which we found compensable. The medical evidence does not support SAIF's theory.

Dr. Swanson described the avascular necrosis disease as a continuum, explaining that, as a result of his work injury causing collapse of the necrotic bone, claimant's disease had progressed to the point where he had symptoms which caused disability and required medical treatment. It is this "resultant" condition - the avascular necrosis disease combined with claimant's work injury which caused collapse of the femoral head - that is compensable. Based on Dr. Swanson's description of the disease process, we find that the avascular necrosis disease is an integral part of the "resultant" condition; the "resultant" condition is simply an advanced stage of the necrosis disease, which claimant reached as a result of the work injury causing collapse of the femoral head.

Consequently, we disagree with SAIF's assertion that we did not find it responsible for claimant's current avascular necrosis condition. Therefore, we decline SAIF's request to modify our decision to affirm the Referee's order which set aside SAIF's denials in their entirety.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our June 4, 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
JORGE BEDOLLA, Claimant
WCB Case No. 91-12374
ORDER ON REVIEW (REMANDING)
Michael B. Dye, Claimant Attorney
Cummins, et al., Defense Attorneys
Les Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Myers' 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 injury claim in June 1990. The claim was accepted for right shoulder strain and compression fracture at L-1. His claim was closed by a February 28, 1991, Determination Order with an award of temporary disability and 13 percent (41.6 degrees) unscheduled permanent disability.

Claimant requested reconsideration of the Determination Order. The record does not contain claimant's request for reconsideration. On August 29, 1991, an Order on Reconsideration issued which affirmed the Determination Order.

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 August 29, 1991 Order on Reconsideration are applicable. Former OAR 436-30-003(4) (WCD Admin. Order 33-1990, effective December 26, 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. Buttler, 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 Determination Order. Without evidence of the basis for claimant's challenge to the Determination Order, we are unable to determine whether or not claimant objected to the attending physician's findings regarding impairment. Peter L. Galiano, 44 Van Natta 1197 (1992). 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 November 29, 1991 is vacated. This matter is remanded to Referee Myers 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). After receipt of that evidence, the Referee shall issue a final, appealable order.

ORDER

The Referee's order dated November 29, 1991 is vacated. This matter is remanded to Referee Myers for further proceedings consistent with this order.

In the Matter of the Compensation of
MARY E. LOVELL, Claimant
WCB Case No. 91-05330
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Davis' order that: (1) upheld the self-insured employer's denial of claimant's cervical injury claim; and (2) declined to assess penalty, or attorney fees for an allegedly unreasonable denial. On review, the issues are compensability, penalties, and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Without addressing whether claimant experienced a compensable injury during the on-the-job lifting incident, the Referee concluded that this incident was not the major contributing cause of a worsening of claimant's preexisting degenerative cervical condition. We find that claimant sustained a compensable injury during the lifting incident. However, we agree with the Referee that the preexisting cervical condition was the major contributing cause of claimant's need for treatment and disability.

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); LaDonna F. Burk, 44 Van Natta 781 (1992). 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; LaDonna F. Burk, supra.

We find that the question of whether claimant sustained a compensable injury and 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).

As discussed by the Referee, the record clearly establishes that claimant had a preexisting degenerative disc disease in her cervical spine. Also, the evidence shows that, on December 27, 1990, a Thursday, claimant felt a "pop" in her neck when she lifted a patient's legs while transferring him from a gurney to an x-ray table. Claimant did not feel pain until Saturday, December 29, 1990, and she went to the Emergency Room the next day. (Ex. 16, 17, 19). Dr. Blaylock, the Emergency Room physician, noted decreased range of motion and diagnosed "acute cervical strain with radiculopathy." (Exs. 17-2, 18). He also referred claimant to Dr. Mason, neurological surgeon. (Ex. 17-2).

On January 15, 1991, Dr. Mason examined claimant and noted limited cervical movement. (Ex. 23-2). Dr. Mason opined that the December 1990 incident caused an exacerbation of claimant's cervical pain. (Ex. 26). On February 20, 1991, Dr. Wilson, neurologist, and Dr. Mayhall, orthopedist, both of whom represent Medical Consultants Northwest, performed an independent medical examination of claimant and a complete record review. They opined that the December 1990 incident might have worsened claimant's symptoms. (Ex. 28-8). Although this possibility is not sufficient to establish a compensable injury, it does support Dr. Mason's opinion regarding an exacerbation of pain resulting from a work incident. Gormley v. SAIF, 52 Or App 1055 (1981). On this record, we find that claimant has established a compensable injury in that she suffered an injury arising out of and in the course of

her employment and that injury, which is supported by objective medical findings, was a material contributing cause of her cervical disability or need for medical treatment.

However, the medical evidence demonstrates that claimant's preexisting cervical condition combined with her compensable injury to cause or prolong disability or need for treatment. (Exs. 14, 23, 26, 28). Therefore, claimant must prove that the major contributing cause of the resulting condition is the compensable injury. ORS 656.005(7)(a)(B); Bahman M. Nazari, supra; LaDonna F. Burk, supra. Claimant does not meet this burden of proof.

Dr. Mason noted that claimant continued to be symptomatic following her initial noncompensable cervical injury in November 1989. (Ex. 23-1). This is supported by the record. (Ex. 14, 15, Tr. 39). On February 19, 1991, Dr. Mason opined that, although the December 1990 work incident caused an exacerbation of claimant's symptoms, her preexisting condition was the major cause of her current condition. (Ex. 26). On July 2, 1991, in a check-the-box opinion, Dr. Mason stated that the December 1990 incident was the major contributing cause of the disability or need for treatment. (Ex. 32-2). However, Dr. Mason offered no explanation for this change of opinion. We do not find this unexplained change of opinion persuasive. Moe v. Ceiling Systems, 44 Or App 429 (1980); Raul A. Herrera, 40 Van Natta 1281 (1988).

Instead, we rely on the consistent and well-reasoned opinions of Drs. Wilson and Mayhall who opined that the major contributing cause of claimant's current condition was her preexisting degenerative disc disease, not the December 1990 work incident. (Ex. 28-6). Furthermore, Drs. Wilson and Mayhall noted that claimant's x-rays remained unchanged between the examinations in November 1989 and December 1990. (Ex. 20, 28-7). Relying on the report of Drs. Wilson and Mayhall, we conclude that claimant's compensable December 27, 1990 injury is not the major contributing cause of her resulting condition. Accordingly, although claimant has established that the work injury in December 1990 was a material cause of her immediate need for medical services and/or disability, she has failed to establish that the December 1990 injury is the major contributing cause of the resultant cervical condition. Tony L. Rivord, 44 Van Natta 1036 (1992); Bruce L. Hirschkorn, 43 Van Natta 2535 (1991).

Penalties and Attorney Fees - Allegedly Unreasonable Denial

Claimant argues that she is entitled to penalties and attorney fees based on the employer's allegedly unreasonable denial. 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); see Carol J. Knapp, 41 Van Natta 851, 854 (1989).

Here, at the time of the denial, the employer had Dr. Mason's initial report which noted that claimant's history was compatible with cervical nerve root irritability and that claimant showed a lot of degenerative arthritic changes in her cervical spine. (Ex. 23-2). This report was sufficient to create a legitimate doubt as to the employer's liability. Accordingly, we find that the denial was not unreasonable.

Attorney Fees At Hearing and On Review

Because we find that claimant has established a compensable injury relating to the December 27, 1990 work incident, claimant is entitled to an assessed attorney fee pursuant to 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 setting aside the employer's denial of the December 27, 1990 compensable injury is $1,500, 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 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 September 13, 1991 is affirmed in part and reversed in part. The self-insured employer's February 19, 1991 denial is set aside in part and upheld in part. In as much as the employer's denial challenged the compensability of the entire claim, to the extent that it denied the compensability of the December 27, 1990 work injury itself, that portion of the denial is set aside. To the extent that the denial denied claimant's resulting condition, that portion of the denial is upheld. The injury claim is remanded to the employer for further processing according to law. For services at hearing and on Board review concerning the compensability issue, claimant's counsel is awarded an assessed fee of $1,500, payable by the employer. The remainder of the order is affirmed.

In the Matter of the Compensation of
BILLIE J. PETERSON, Claimant
WCB Case Nos. 91-09147 and 91-08483
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of Referee Peterson's order that: (1) increased claimant's scheduled permanent disability award for loss of use or function of the leg (knee) from 24 percent (36 degrees), as awarded by a Reconsideration Order, to 28 percent (42 degrees); (2) affirmed the award of temporary disability made by a Reconsideration Order; and (3) directed SAIF to pay claimant's scheduled permanent disability award at the rate of $305 per degree. On review, the issues are extent of scheduled permanent disability, temporary disability, and rate of scheduled permanent disability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability

We adopt the Referee's reasoning and conclusions regarding the issue of temporary disability benefits.

Extent of Scheduled Permanent Disability

We adopt the Referee's reasoning and conclusions regarding the issue of extent of scheduled permanent disability with the following supplementation.

SAIF argues that the standards enacted by WCD Admin. Order 15-1990 should be applied to claimant's claim. However, former OAR 436-35-003(1) provides that those standards "govern all evaluations of a worker's disability made pursuant to ORS Chapter 656 on or after October 1, 1990." WCD Admin. Order 15-1990. Here, claimant's knee claim was evaluated and closed by Notice of Closure issued September 27, 1990. Thus, by its own terms, WCD Admin. Order 15-1990 does not apply to claimant's claim. Instead, the standards applicable to claimant's claim are those enacted by WCD Admin. Order 7-1988. See WCD Admin. Order 1-1989; former OAR 438-10-010, effective April 1, 1989. These are the standards applied by the Referee.

Relying on former OAR 436-35-007(5), SAIF argues that claimant's previously accepted right ankle condition has improved and that this improvement should be considered in rating the extent of the total scheduled permanent impairment in her right leg. The Referee found this argument to be without merit. We agree. Assuming arguendo that claimant's ankle condition has improved, SAIF's

argument fails on two grounds. First, the provision upon which SAIF relies does not exist in the standards applicable to claimant's case. Second, even if this provision were applicable, it could not be applied in the manner proposed by SAIF. The last sentence of that provision provides that "[i]f a claim has multiple accepted conditions, only those conditions which have permanently worsened shall be redetermined." Former OAR 436-35-007(5); WCD Admin. Order 15-1990. This provision allows for redetermination of worsened conditions, not improved conditions.

Rate of Scheduled Permanent Disability

The Referee concluded that claimant's award of scheduled permanent disability should be paid at the rate of $305 per degree. The Referee relied on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), in which we held that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. Subsequent to the Referee's order, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992).

In this case, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury. ORS 656.202(2); Former ORS 656.214(2).

Attorney Fee on Review

Claimant's attorney is entitled to an assessed attorney fee for prevailing against SAIF's request for review regarding the issues of extent of permanent disability and temporary disability benefits. 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 $1,150, to be paid by the SAIF Corporation. 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 November 1, 1991 is affirmed in part and reversed in part. That portion of the order that directed the SAIF Corporation to pay claimant's scheduled permanent disability award at the rate of $305 per degree is reversed. The remainder of the order is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $1,150, to be paid by the SAIF Corporation.

July 22, 1992 Cite as 44 Van Natta 1505 (1992)

In the Matter of the Compensation of
DEREK J. SCHWAGER, Claimant
WCB Case No. 90-19402
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Black's order that granted the SAIF Corporation's motion to dismiss on the ground that claimant's "new injury" claim for a low back condition was barred by res judicata. On review, the issue is res judicata. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The sole question is whether claimant's "new injury" claim for a low back condition is barred by principles of res judicata. The Referee concluded that it was and granted SAIF's motion to dismiss. We affirm.

"Preclusion by former adjudication," generally referred to as res judicata, is a "doctrine of rules and principles governing the binding effect on a subsequent proceeding of a final judgment previously entered in a claim." Drews v. EBI Companies, 310 Or 134 (1990). The term comprises two doctrines, claim preclusion and issue preclusion. Issue preclusion bars future litigation of a subject issue only if that issue was actually litigated and determined in a setting where the determination of that issue was essential to the final decision reached. North Clackamas School Dist. v. White, 305 Or 48 (1988). In comparison, claim preclusion bars future litigation not only on every claim included in the pleadings, but also every claim that could have been alleged under the same aggregate of operative facts. Million v. SAIF, 45 Or App 1097, rev den, 289 Or 337 (1980). Claim preclusion does not require actual litigation of an issue; however, it does require the opportunity to litigate, whether or not used. Drews, supra.

The issue of whether claimant sustained a "new injury" when he fell at work on July 10, 1989 was not adjudicated at the prior hearing before Referee McCullough. That decision settled only whether claimant had established a worsened condition resulting from his original compensable injury pursuant to ORS 656.273(1). Accordingly, we agree with claimant that issue preclusion does not bar the present claim. We conclude, however, that claim preclusion is applicable.

In Million v. SAIF, supra, the court applied claim preclusion to bar an occupational disease claim for a shoulder condition where the claimant had earlier tried and lost a claim for a worsened condition for the same condition. In that case, the claimant suffered a compensable injury to her hand in 1972. She subsequently developed shoulder pain and, in 1975, she unsuccessfully sought compensation for a shoulder operation as an aggravation of her 1972 injury. The claimant later sought compensation for the shoulder operation on the new theory that the condition was caused by an occupational disease. The court concluded that the failure to assert both theories for recovery in the first compensation claim precluded the second claim on the second theory, because finality had attached to the first claim and there was an opportunity to litigate both claims at the time of the first. It explained:

> "We think the evidence shows that claimant and her attorney were, at the time of filing her aggravation claim in 1975, aware that it was also possible that her shoulder condition was, in whole or in part, the product of an occupational disease. Under the circumstances, a claim on this theory should have been made in 1975." 45 Or App at 1103.

We find the same reasoning applicable here. Claimant does not contend that his low back condition is different, or has changed, from his condition at the time of the earlier final adjudication. See Proctor v. SAIF, 68 Or App 333 (1984); Arthur D. Esgate, 44 Van Natta 875 (1992); Irene Jensen, 42 Van Natta 2838 (1990). Rather, he merely asserts that his condition is the result of a "new injury," rather than an aggravation. Contrary to claimant's contention, basing this claim on a "new injury" theory, as opposed to an aggravation premise, does not create a different cause of action. As in Million, the present claim for relief arises out of the same aggregate of operative facts. Because it is clear that claimant could have asserted both theories of compensability in the previous adjudication, we conclude that the present claim is barred by principles of res judicata.

ORDER

The Referee's order dated October 11, 1991 is affirmed.

In the Matter of the Compensation of
CYNDI D. TOMLINSON, Claimant
WCB Case Nos. 91-03503 & 90-21854
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of that portion of Referee Gruber's order that awarded claimant 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the right forearm and 5 percent (7.5 degrees) for loss of use or function of the left forearm, whereas a Determination Order had not awarded any scheduled permanent disability. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee found that, as a result of her compensable injury, claimant had chronic loss of repetitive use of her forearms and awarded 5 percent scheduled permanent disability for each arm. We disagree.

Extent of scheduled permanent disability is measured by the permanent loss of use or function of the injured member due to the industrial injury. ORS 656.214(2).

Inasmuch as the Referee concluded that claimant's current bilateral arm condition was not compensable, and that finding was not appealed, we find that the issue of whether claimant has sustained any permanent impairment as a result of her compensable injury to be a complex medical question. Thus, although claimant's testimony is probative, the resolution of this issue largely turns on an analysis of the medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

In April 1990, Dr. Hayes, claimant's treating physician, indicated that claimant's left hand was not stationary, but reported that her right hand was stationary with no permanent impairment in her right hand. In June 1990, Dr. Hayes reported that both of claimant's hands were medically stationary and indicated that no further treatment was necessary.

Following claim closure, claimant continued to complain of persistent pain in both forearms and hands. Dr. Hayes opined that these symptoms were not due to her compensable carpal tunnel syndrome or subsequent surgeries. Thereafter, claimant was referred to a number of physicians all of whom indicated that claimant's chronic complaints were not supported by objective findings and could not relate her complaints to the compensable carpal tunnel syndrome or subsequent surgeries.

Under these circumstances, we conclude that claimant has not established that she sustained a chronic loss of repetitive use in her forearms that is due to the compensable injury. Accordingly, claimant is not entitled to an award of scheduled permanent disability. ORS 656.214(2). In reaching this conclusion, we acknowledge that the Referee's award was based on claimant's testimony. However, assuming arguendo that claimant's chronic complaints are due to the compensable condition, claimant's testimony does not by itself establish the existence of a chronic condition. Kathleen A. Hoff, 43 Van Natta 2620 (1991); Ruben Carlos, 43 Van Natta 605 (1991).

ORDER

The Referee's order dated August 15, 1991 is reversed. The Referee's award of 5 percent (7.5 degrees) scheduled permanent disability for the left wrist and 5 percent (7.5 degrees) scheduled permanent disability for the right wrist is reversed.

In the Matter of the Compensation of
JACQUELINE C. TONISSEN, Claimant
WCB Case No. 91-06321
ORDER ON REVIEW
Phil H. Ringle, Jr., Claimant Attorney
Thomas Ewing (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband

The SAIF Corporation requests review of that portion of Referee Daughtry's order that found that claimant was entitled to vocational assistance. Additionally, SAIF requests that we remand this matter for the taking of further evidence. In her brief, claimant cross-requests review of those portions of the Referee's order that: (1) declined to assess a penalty for SAIF's allegedly unreasonable denial of vocational assistance; and (2) declined to award an assessed attorney fee for prevailing over SAIF's denial of vocational assistance. On review, the issues are remand, vocational assistance, penalties, and attorney fees. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Remand

SAIF requests that we remand this matter for further evidence concerning the number of hours per week claimant worked at her at-injury job.

Remand is appropriate if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Here, the record is sufficiently developed with regard to the number of days that claimant worked at her "at injury" job. Moreover, the bulletin referred to by SAIF indicates that to determine eligibility of a worker who is employed part-time, the wage calculation shall be based on a 40 hour work week. The provision does not require the worker to have worked 40 hours per week, but rather requires the wage calculation to be based on a 40 hour work week. Accordingly, we conclude that remand is not appropriate in this instance.

Vocational Assistance

We adopt the conclusions and reasoning concerning claimant's entitlement to vocational assistance as set forth in the Referee's order.

Penalties

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

Attorney Fees

Claimant contends that she is entitled to an assessed attorney fee pursuant to ORS 656.386(1) for prevailing over SAIF's denial of vocational assistance. We disagree.

The court has held that an attorney fee under ORS 656.386(1) is not available for services rendered in conjunction with obtaining vocational assistance. See Simpson v. Skyline Corporation, 108 Or App 721 (1991). Accordingly, we decline to award such an attorney fee.

Attorney Fee/Board 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 vocational assistance issue is $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 claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated September 23, 1991 is affirmed. For services on review concerning the vocational assistance issue, claimant's counsel is awarded an assessed attorney fee of $500, payable by the SAIF Corporation.

July 23, 1992 Cite as 44 Van Natta 1509 (1992)

In the Matter of the Compensation of
IRWIN W. GEER, Claimant
WCB Case Nos. 92-01980 & 91-17845
ORDER OF DISMISSAL
Kirkpatrick & Zeitz, Claimant Attorneys
Beers, et al., Defense Attorneys

The SAIF Corporation has requested review of Referee Crumme's June 15, 1992 "Order of Abatement," which purported to abate the Referee's May 13, 1992 Opinion and Order. Contending that the Referee lacked authority to abate the May 13, 1992 order because it became final by operation of law prior to the Referee's June 15, 1992 order, SAIF asks that we vacate the Referee's abatement order. We dismiss the request for Board review.

FINDINGS OF FACT

On May 13, 1992, copies of the Referee's Opinion and Order were mailed to all parties to the proceeding. On June 8, 1992, the Board's Portland office received claimant's motion for reconsideration of the Referee's May 13, 1992 order. Submitting additional evidence, claimant also sought reopening of the record.

On June 11, 1992, the Board's Portland office received a response to claimant's motion from the SAIF Corporation. If the Referee chose to abate the May 13, 1992 order, SAIF asked that it be granted an opportunity to further respond.

On June 15, 1992, copies of the Referee's Order of Abatement were mailed to all parties to the proceeding. On June 26, 1992, the Board's Portland office received SAIF's motion to dismiss the Referee's abatement order. Noting that the 30th day from the May 13, 1992 order had been Friday June 12, 1992, SAIF contended that the Referee lacked authority to issue the June 15, 1992 order.

On June 29, 1992, copies of the Referee's "Order" were mailed to all parties to the proceeding. Responding to SAIF's motion, the Referee stated that he had signed the abatement order on June 11, 1992, but had "no information other than that the Order of Abatement was mailed on June 15, 1992, as indicated on the Order."

On July 6, 1992, the Board's Portland office received claimant's response to SAIF's motion. Because the Referee had signed the abatement order prior to the expiration of the statutory 30-day period, claimant contended that the May 13, 1992 order had been effectively abated. Claimant further asserted that he "should not suffer because of a secretarial mess up in the Hearings Division."

On July 6, 1992, copies of the Referee's "Notice of Ex Parte Communication" were mailed to all parties to the proceeding. The Referee reported that he had engaged in a June 15, 1992 phone conversation with claimant's counsel and had advised counsel that the abatement order had been signed June 11, 1992 but not mailed until June 15, 1992.

On July 10, 1992, SAIF mailed by certified mail its request for review of the Referee's June 15, 1992 order to the Board. Contending that the Referee had refused to acknowledge that he lacked

authority to abate the May 13, 1992 order, SAIF argued that it had "no other remedy than this 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). The time within which to appeal an order continues to run, unless the order had been "stayed," withdrawn or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986); Leon C. Buzard, 40 Van Natta 595 (1988).

Here, SAIF requested Board review on July 10, 1992, which is within 30 days of the Referee's June 15, 1992 "Order of Abatement." Yet, the June 15, 1992 order was not a "final order" in that it did not purport to finally determine the amount of, or entitlement to, claimant's compensation. See Price v. SAIF, 296 Or 311, 315 (1984); Lindamood v. SAIF, 78 Or App 15, 18 (1986); Mendenhall v. SAIF, 16 Or App 136, 139 (1974). Thus, we lack authority to consider SAIF's request for review of the Referee's June 15, 1992 order.

In light of the confusing circumstances detailed above, SAIF's request for review can also be interpreted as an appeal of the Referee's May 13, 1992 Opinion and Order. If viewed as such a request, we would also dismiss SAIF's appeal. Our conclusion is based on the following reasoning.

Claimant's motion for reconsideration of the Referee's May 13, 1992 order was filed within 30 days of the date the order was mailed to all parties to the proceeding. Nevertheless, the filing of such a motion cannot effect a stay of the Referee's order. McCormac v. Cottage Crafts, 113 Or App 173 (May 20, 1992). Rather, the time for appeal of the Referee's May 13, 1992 order would continue to run unless the order was abated, withdrawn, stayed, modified, or republished before the expiration of the statutory 30-day appeal period. ORS 656.289(3); International Paper Co. v. Wright, supra; Fischer v. SAIF, supra.

The Referee apparently signed the abatement order on June 11, 1992, prior to the expiration of the 30-day appeal period. However, the order was not mailed to all parties to the proceeding until June 15, 1992, which is more than 30 days after the May 13, 1992 order. Inasmuch as the statutory scheme for the issuance of Referee and Board orders is premised on the date of mailing, it follows that an abatement order does not become effective until copies of the order are mailed to all parties to the proceeding. See Taylor v. Liberty Northwest Insurance Corp., 107 Or App 107 (1991) (Referee's order not effective until copies of the order are mailed to all parties to the proceeding).

Here, by the time copies of the Referee's June 15, 1992 abatement order had been mailed to the parties, the 30-day statutory appeal period from the May 13, 1992 order had expired. Consequently, the Referee's May 13, 1992 order had become final by operation of law. ORS 656.289(3); International Paper v. Wright, supra; Fischer v. SAIF, supra. Thus, the Referee's June 15, 1992 order is a nullity.

It is regrettable that copies of the Referee's abatement order were not timely mailed to the parties. As does the Board, Referees attempt to respond to motions for reconsideration as expeditiously as possible. Nevertheless, the ultimate responsibility for preserving a party's appeal rights must rest with each party. See Connie A. Martin, 42 Van Natta 495, 853 (1990).

In conclusion, based on the aforementioned reasoning, we hold that we are without authority to consider the request for review. Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN R. JOHANSON, Claimant
WCB Case No. 91-11002
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of that portion of Referee Quillinan's order that affirmed an Order on Reconsideration which awarded no permanent disability. On review, the issue is extent of scheduled permanent partial disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On review, claimant asserts only that he is entitled to a 5 percent scheduled permanent partial disability award for a chronic condition limiting repetitive use of his left foot. Consequently, under the applicable standards, claimant must show that a preponderance of medical opinion establishes that he is unable to repetitively use his left foot due to a chronic and permanent medical condition. See former OAR 436-35-010(6).

Claimant principally relies on a letter drafted by the self-insured employer's attorney stating that Dr. Bailey, D.P.M., claimant's treating physician, had "indicated that [claimant] does not seem to have any particular problems with walking or standing, but does have problems if he has to use the foot for heavy, repetitive work, such as in operating foot controls[.]" (Ex. 27-1). Claimant also relies on a report from the Orthopaedic Consultants, which conducted an independent medical examination, stating that claimant "has tenderness in the left heel and this is increased when he tries to walk on his heel." (Ex. 34-5).

We do not find such evidence sufficient to carry claimant's burden under former OAR 436-35-010(6). First, we find that the statement from the Orthopaedic Consultants in no way indicates that claimant is unable to repetitively use his left foot due to a chronic and permanent condition. Furthermore, the letter reporting Dr. Bailey's statements also stated that he "really could not distinguish the effects of the [compensable] heel spur and the [noncompensable] tarsal tunnel syndromes, since those problems tend to manifest themselves in very much the same kind of symptoms and it is difficult to segregate the effects of one from the effects of the other," (Ex. 27-1), thereby indicating that claimant's symptoms are not solely due to his compensable injury. Dr. Bailey also attributed an additional, albeit minimal, portion of claimant's complaints to his noncompensable neuroma. Claimant nevertheless argues that he has proved loss of repetitive use of his left foot on the basis that, under Barrett v. D & H Drywall, 300 Or 325 (1985), clarified 300 Or 553 (1986), "when a compensable condition combines with a noncompenable condition, and it is impossible to separate the components of disability, the disability is rated unitarily."

The Court in Barrett held that, when a compensable injury was superimposed upon a preexisting condition, then the extent of disability caused by the industrial accident included consideration of the "loss of earning capacity, if any, resulting from symptoms caused by the injury." 300 Or at 331. In a clarifying opinion, the Court emphasized that only when an industrial accident causes a preexisting disease "to produce symptoms where none existed immediately prior to the acident, and those symptoms produced loss of earning capacity, then that loss of earning capacity is 'due to' the compensable injury, and the statute requires an award of compensation therefor." 300 Or at 556.

Here, neither claimant nor our own review of the record indicates that claimant's compensable injury caused his noncompensable conditions to become symptomatic. Therefore, we find Barrett to be distinguishable from this case. Furthermore, the standards provide in relevant part that:

> "Where a worker's impairment findings are due to the accepted injury or accepted conditions and the findings are also due to other unrelated and/or noncompensable causes, the combined findings are rated and valued under these rules. After the total amount of disability has been determined, that portion or percentage of the permanent disability that is attributable to the noncompensable or unrelated causes by a preponderance of medical opinion shall be deleted from the total and the worker shall receive an award for the remainder of the disability."

Former OAR 436-35-007(2). Here, we find that, because Dr. Bailey was unable to state what portion or percentage, if any, of claimant's symptoms are attributable to his compensable injury, we are unable to determine claimant's entitlement, if any, to permanent impairment. Therefore, we affirm the Referee's order.

ORDER

The Referee's order dated November 19, 1991 is affirmed.

In the Matter of the Compensation of
ROBERT H. McALLISTER, Claimant
WCB Case No. 91-04069
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Charles A. Ringo, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Mongrain's order that upheld the insurer's denial of his right hip avascular necrosis condition. On review, claimant submits a copy of a medical opinion not admitted into evidence at hearing. We treat such submissions as a motion for remand. In its brief, the insurer requests review of that portion of the Referee's order that set aside its denial of claimant's right femur fracture. On review, the issues are remand 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

Remand

On review, claimant contends that the Referee addressed an issue that was not ripe for hearing, i.e., the issue of compensability of claimant's right hip surgery. Claimant argues that, because the matter was not properly before the Referee, claimant did not have an opportunity to provide evidence on that issue. Therefore, claimant contends that this matter should be remanded for consideration of a medical report generated after the record had closed.

We may remand a case to the Referee for further evidence taking if we determine that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

Here, we find that the issue before the Referee was compensability of claimant's right hip condition. Although the Referee addressed claimant's hip replacement surgery, it was based upon his finding that claimant's injury was not the major cause of his need for treatment, rather than a finding, for example, that the surgery was not reasonable or necessary. Under the circumstances, we do not find that the record was improperly or insufficiently developed. Claimant's request for remand is, therefore, denied.

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 Or Laws, ch. 2, Section 54(2); Ida M. Walker, 43 Van Natta 1402 (1991).

The Referee found that claimant's right femur fracture was compensable. However, he found that claimant's right avascular necrosis condition was not compensable. We do not agree that claimant's right hip condition is not compensable.

Subsequent to the Referee's order, we held that, in cases involving preexisting conditions, compensability of a claim involves a two-part test. Bahman M. Nazari, 43 Van Natta 2368 (1991). First, claimant must establish that he suffered an accidental injury arising out of and in the course of employment, which was a material contributing cause of his 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 his injury remained the major contributing cause of his resulting disability. ORS 656.005(7)(a)(B); Bahman M. Nazari, supra.

Here, we agree with the Referee's conclusion that claimant established compensability of an injury on October 9, 1990, and we adopt his "Opinion" on that issue. See Mark N. Wiedle, supra.

The Referee next concluded that, pursuant to ORS 656.005(7)(a)(B), claimant had failed to establish that the compensable injury was the major contributing cause of his disability or need for treatment. The Referee apparently found that claimant's preexisting avascular necrosis condition, rather than his compensable injury, was the major cause of his need for treatment. We apply the following analysis.

In regard to the second prong of the compensability test required under ORS 656.005(7)(a)(B), 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).

In February 1991, Dr. Weinman, claimant's treating physician, reported that claimant may or may not have had avascular necrosis of the hip at the time he stepped off the scaffolding at work. Dr. Weinman concluded that it was medically probable that claimant's current need for a total hip replacement was related to the work injury.

In March 1991, Dr. Woolpert, independent medical examiner, reported that claimant had a preexisting pathological process which was "going on and with a fairly minor trauma that there began to be symptoms in respect to the right hip." Dr. Woolpert did not believe that claimant's work incident was the major cause of his avascular necrosis.

On April 2, 1991, Dr. Weinman disagreed with Dr. Woolpert's conclusions. Dr. Weinman stated that it was medically probable that claimant's (avascular necrosis) condition was aggravated, and his symptoms "begun by the injury of 10/9/90." On May 6, 1991, Dr. Weinman reported that his April 2, 1991 letter should be read to state that claimant's injury "is the major contributing incident to his need for surgery on the right."

On May 9, 1991, Dr. Potter, independent medical examiner, reported that he did not agree with Dr. Weinman that the injury caused claimant's avascular necrosis. Dr. Potter reported that, because there was evidence of bilateral necrosis and claimant had only injured the right hip, he could not agree with Dr. Weinman's statements.

On May 23, 1991, Dr. Weinman reported that claimant suffered from bilateral avascular necrosis prior to the October 9, 1990 injury. He also opined that the injury aggravated the underlying condition and caused it to become symptomatic (although only in the right hip). Finally, Dr. Weinman reiterated

that the injury was the major contributing "incident to his need for total hip replacement on the right." Dr. Weinman concluded, however, that the injury was not a major cause of claimant's need for treatment for his left hip.

We conclude that, on the issue of causation of claimant's current disability, Dr. Weinman, claimant's treating physician, has provided the most persuasive opinion. We note that we have above agreed with the Referee's reliance upon the opinion of Dr. Weinman in regard to the causation of claimant's right femur fracture, and for similar reasons, we find his opinion on claimant's current condition to be the most persuasive medical evidence on the record.

Moreover, because the independent medical examiners, Dr. Woolpert and Dr. Potter, did not agree that claimant sustained a right femur fracture, we are not persuaded by their opinions on the issue of causation of claimant's disability or need for treatment. Additionally, we do not find Dr. Potter's opinion persuasive, as he disagreed with Dr. Weinman's opinion on the basis that Dr. Weinman informed claimant that his injury caused his avascular necrosis. However, Dr. Weinman specifically denied that he had told claimant that his necrosis condition was caused by his injury.

Furthermore, in addition to addressing both claimant's fracture and his necrosis condition, Dr. Weinman also explained the difference between claimant's current left and right hip conditions and noted that x-rays of the right hip showed collapse of a subchondral bone on the right (attributable to his subchondral fracture) which was not present in x-rays of the left hip. Finally, considering the injury which resulted in the fracture and the aggravation of the underlying necrosis condition, causing the condition to become symptomatic, Dr. Weinman concluded that the injury was the major cause of claimant's disability and need for treatment.

We conclude, relying upon Dr. Weinman's opinion, that the work injury of October 9, 1990 combined with claimant's preexisting necrosis condition and resulted in claimant's disability and need for medical treatment. We further find that the work injury was the major contributing cause of the resultant condition, which includes a subchondral fracture and a collapsed subchondral bone on the right. Accordingly, we find that the compensable injury combined with the preexisting necrosis condition, and that 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); Dale P. Ballou, 44 Van Natta 1087 (1992) on recon 44 Van Natta 1499 (1992).

Accordingly, we reverse that portion of the Referee's order that set aside the insurer's denial of claimant's right avascular necrosis condition. In reaching this conclusion, we wish to emphasize that we are finding claimant's current resultant disability and medical treatment compensable. In this case, claimant's resultant condition, as reported by Dr. Weinman, consists of his subchondral fracture and collapsed subchondral bone on the right which have combined with the necrosis to cause his need for treatment. Consequently, it is this condition that we find to be compensable. See Dale P. Ballou, supra (Underlying aseptic/avascular necrosis condition is not separate and distinct from the "resultant" condition which was found to be compensable and thus claimant's current necrosis condition is compensable).

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 at hearing and on review concerning compensability of the right avascular necrosis condition is $1,500, payable 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 29, 1991, as supplemented by the July 30, 1991 order, is reversed in part and affirmed in part. That portion of the Referee's order that upheld the insurer's denial insofar as it denied medical services and/or disability for claimant's right hip condition is set aside. The claim is remanded to the insurer for acceptance and processing according to law. For services at hearing and on review concerning the issue of compensability, claimant's counsel is awarded an assessed attorney fee of $1,500, payable by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
JEFFREY W. NELSON, Claimant
WCB Case Nos. 91-00636, 90-21224, 91-00637 & 90-21225
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Roberts, et al., Defense Attorneys
Janice M. Pilkenton, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Safeco Insurance Company (Safeco) requests review of those portions of Referee/Arbitrator Daron's orders which: (1) set aside Safeco's denial of claimant's "new injury" claim for a low back condition; (2) upheld the Travelers Insurance Company's (Travelers) denial of claimant's medical services claim for the same condition; and (3) awarded claimant's counsel a $2,500 carrier-paid fee, to be paid by Safeco. On review, the issues are the standard of review, responsibility and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact as contained in his "Opinion and Order" and "Arbitrator's Decision."

CONCLUSIONS OF LAW AND OPINION

We agree with the Referee's decision that Safeco is responsible for claimant's low back condition, as well as a $2,500 attorney fee. However, we base our conclusion on the following reasoning.

Claimant compensably injured his low back in August 1980 while working for Travelers' insured. This claim was closed with no award of permanent disability. On September 14, 1990, while working for Safeco's insured, claimant experienced a sudden onset of severe low back pain which was subsequently diagnosed as an acute lumbosacral sprain/strain. On September 27, 1990, Safeco denied that the September 14, 1990 incident constituted a new injury. Instead, Safeco contended that claimant's condition was a continuation of the 1980 injury at Travelers' insured. Safeco's letter also denied that Safeco was responsible for claimant's current need for treatment. However, Safeco eventually conceded to a ".307" order which was issued on January 11, 1991. Safeco did not reassert compensability as an issue. Travelers also denied responsibility on November 1, 1990. After a consolidated hearing, the Referee issued an order concluding that claimant's claim for a low back condition was compensable as a "new injury." The Referee also issued an "Arbitrator's Decision" assigning responsibility to Safeco.

Standard of Review

On review, Safeco first contends that the Referee's order was procedurally improper because compensability was not at issue. It further argues that the order is, therefore, moot and should be vacated or, alternatively, if the order is not vacated, the Board's standard of review should be de novo.

ORS 656.307 provides for formal arbitration of responsibility cases. Subsection (2) provides that the Director initiate the arbitration proceeding by referring the matter to the Board for appointment of the arbitrator. The referral is made by issuing a ".307" order. We generally review an arbitrator's responsibility decision only for errors of law. ORS 656.307(2); John L. Riggs, III, 42 Van Natta 2816 (1990).

Here, the matter was referred to the Board through issuance of a ".307" order. However, the ".307" order issued just before hearing and the Referee felt compelled to determine by order whether claimant had sustained a "new compensable injury" pursuant to the amended responsibility law. Consequently, the Referee issued both an order addressing compensability and an "Arbitrator's Decision" addressing responsibility, incorporating the compensability order by reference into the "Arbitrator's Decision." (See Ex. 35 and Tr. 4). Finally, the Referee issued a third order dismissing claimant's request for hearing against Travelers. The Referee reasoned that that case was limited to

medical benefits only and had been superceded by the issue referred for hearing by the Department's ".307" order.

Inasmuch as a ".307" order was issued, compensability should not have been at issue at the hearing. However, because of the Arbitrator's mistaken belief that ORS 656.308(1) required him to first determine compensability of the claim and to issue a separate Opinion and Order addressing that issue, compensability was brought into contention between the parties. Thus, as a result of the Referee's procedural decision to address compensability of claimant's "new injury" claim, the nature of this ".307" proceeding was effectively destroyed. Under the circumstances, we conclude that our review of the Referee's orders should be de novo. See Linda A. Fuchs-Perrite, 43 Van Natta 926 (1991).[1]

Responsibility

We adopt the conclusions and reasoning contained in the "Opinion and Conclusions" sections of the Referee's order and the "Arbitrator's Decision" concerning the responsibility issue with the following supplementation.

Safeco contends that the Referee erred in failing to apply ORS 656.005(7)(a)(B) to determine whether a new injury occurred at its insured. Safeco asserts that the 1980 compensable injury at Travelers' insured constitutes a "preexisting condition." We disagree.

Subsequent to the Referee's order, we interpreted Section 49 of the amended law, now codified at ORS 656.308(1), to mean that, in cases in which an accepted condition 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).

We have further held that ORS 656.005(7)(a)(B) is not applicable in the responsibility context because it does not determine compensability of the initial injury, but rather only limits a carrier's liability for continuing disability or need for medical services. Rosalie S. Drews, 44 Van Natta 36 (1992); Bahman M. Nazari, 43 Van Natta 2368 (1991). Moreover, we have previously rejected arguments, similar to the one advanced in this case by Safeco, that a prior, compensable injury constitutes a preexisting disease or condition under ORS 656.005(7)(a)(B). Rosalie S. Drews, supra. Thus, in order to prove a "new compensable injury," Travelers had to establish that the September 14, 1990 incident at Safeco's insured was a material contributing cause of claimant's current disability or need for treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991).

Following our de novo review of the record, we concur with the Referee that Travelers has carried its burden of establishing that claimant sustained a new compensable injury while working for Safeco's insured. Accordingly, we affirm the Referee's conclusion that responsibility for claimant's current disability and need for medical treatment shifts to Safeco.

Attorney Fee at Hearing

Finally, Safeco contends that, because compensability was not at issue, the Referee erred in awarding a $2,500 attorney fee payable by Safeco. We disagree. As discussed above, by virtue of the Referee's procedural rulings, compensability for claimant's "new injury" claim with Safeco was put at

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[1] Noting that the ".307" order was limited in scope to only medical services pertaining to its claim, Travelers contends that the Arbitrator had to issue a separate order addressing the issues which were outside the scope of the Department's ".307" order. Specifically, Travelers reasons that because Safeco's claim was for a new injury and Travelers' claim was for medical services only, when claimant filed a request for hearing on Safeco's denial he "postured for resolution more issues than just those postured by the .307 order." We disagree. The ".307" order concerns responsibility for the acceptance and processing of "a compensable claim." OAR 436-60-180(1)(c). Here, Safeco's claim was for a new injury while Travelers' claim was for medical services only. As a "new injury" claim, claimant's claim with Safeco involved additional benefits than he would receive under his medical services claim with Travelers. Nevertheless, the fact that different benefits flow from these two claims does not limit the scope of the ORS 656.307 arbitration. See OAR 436-60-180(3).

issue. Under such circumstances, we conclude that claimant is entitled to an attorney fee award under ORS 656.386(1), payable by Safeco.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree with the Referee that a reasonable assessed attorney fee for claimant's counsel's services at hearing is $2,500, to be paid by Safeco. 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. Accordingly, we affirm the Referee's $2,500 attorney fee award.

Because the Referee's orders addressed both compensability and responsibility, compensability remained at risk on review. Tanya L. Baker, 42 Van Natta 2818 (1990). Under these circumstances, we conclude that claimant's attorney is entitled to a fee for services on review under ORS 656.382(2) payable by Safeco, the insurer that initiated Board review. See Tanya L. Baker, supra.

After considering the same factors set forth above, we find that a reasonable assessed attorney fee for claimant's counsel's services on review concerning the compensability issue is $1,000, to be paid by Safeco. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate brief and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's orders dated March 14, 1991 are affirmed. For services on Board review concerning the compensability issue, claimant's counsel is awarded a reasonable assessed fee of $1,000, payable by Safeco.

In the Matter of the Compensation of
JACK L. NEWBERRY, Claimant
WCB Case Nos. 91-03861, 91-01498 & 91-03352
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Podnar's order that declined to grant unscheduled permanent partial disability for injuries to claimant's left shoulder, neck, and back. On review, the issue is extent of unscheduled permanent partial disabiltity. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant failed to prove any impairment to entitle him to permanent partial disability benefits. Claimant challenges that conclusion, arguing that he demonstrated impairment under the standards by showing, first, an unoperated disc bulge, second, a loss of range of motion, and, finally, a chronic condition limiting repetitive use of his neck. We disagree with claimant for the following reasons.

We agree with claimant that the medical evidence shows that he(-END-) unoperated cervical bulge and that, under former OAR 436-35-350(2), he need not prove specific impairment resulting from such a condition in order to be entitled to an impairment value. See Cheryl L. McCarthy, 43 Van Natta 654, 655 (1991). However, claimant still must prove that the condition is due to a compensable injury.

See id. at 656. The record is devoid of any evidence linking the cervical bulge to any of claimant's work injuries. On that basis, claimant's contention fails.

Furthermore, although cliamant need not prove specific impairment under former OAR 436-35-350(2), claimant must prove some measurable impairment before any award of unscheduled permanent partial disability may be allowed. See former OAR 436-35-270(2). Claimant contends that he proved impairment with medical evidence showing a loss of range of motion. Specifically, claimant relies on a report by his treating physician, Dr. Breen, M.D., showing limited range of motion in his back and neck. Dr. Breen also stated at that time that claimant "does have permanent impairment" although it is unclear whether he is referring to low back impairment or neck impairment and whether such impairment results from claimant's prior 1984 injury or his subsequent injuries. (Ex. 106-2).

In opposition to the report of Dr. Breen are the independent medical examinations of Drs. Howell, osteopathic surgeon, Simpson, D.C., and Tilden, D.C. The report of Howell and Simpson found that claimant had "multiple complaints with normal physical findings, strong indications of pain due to nonphysical factors." (Ex. 95-10). The report further found "no ratable impairment and there are many indications of pain due to nonphysical factors, indicating that his complaints are not a reliable indication of probable pathology or even an indication that pain and sensitivity to activity is probably experienced." (Id. at 12).

Similarly, Dr. Tilden reported that claimant "has multiple non-anatomic and non-physiologic responses." (Ex. 96-5). The report further stated that the "limitations in ranges of motion exhibited by [claimant] at today's examination are markedly compromised by the multiple non-organic responses. Therefore, his demonstrated limitations of volitional movement are not a valid indication of his objective physical capacity." (Id. at 6).

Dr. Aversano, neurologist, who saw claimant periodically on referral from his then treating chiropractor, Dr. Mills, disagreed with Dr. Tilden's report, stating that Tilden's "conclusions are highly confrontational and suggest an emotional component--an expertise neither he (nor I) share." (Ex. 99). However, Dr. Aversano subsequently agreed "in essence" with the report of Drs. Howell and Simpson. (Ex. 105).

Dr. Howell subsequently reevaluated claimant. Again, he found "multiple complaints with normal objective findings." (Ex. 111-5). The report also stated that claimant had "no objective abnormalities that can account for any of his complaints. * * * There have been and continue to be indications that [claimant's] complaints are due to nonphysical causes which did not arise out of his work injuries." (Id. at 6). Howell found that his conclusions were supported by the fact that claimant's range of motion "differed markedly between [the previous examination] and today and I believe strongly indicates a subjective altering of the physical condition rather than limitations imposed by any physical condition."
(Id. at 7).

Dr. Breen, after reviewing Dr. Howell's report, stated that "he was in agreement with his examination findings and opinions." (Ex. 112).

We find that claimant failed to carry his burden of proof regarding impairment. The only opinion showing a loss of range of motion is that of Dr. Breen. We find, however, that the opinion is outweighed by the reports of Drs. Howell, Simpson, and Tilden. Breen's report is brief and conclusory and, although aware of the reports of Howell, Simpson, and Tilden, provides no response to their conclusion that claimant lacked a physical basis for his symptoms. Howell, Simpson, and Tilden, however, provide a detailed history of claimant's condition, as well as reasoned explanations for their conclusions, and thus are entitled to greater weight. See Somers v. SAIF, 77 Or App 259, 263 (1986). Furthermore, Dr. Breen concurred with the latest report of Dr. Howell, which reiterated Howell's opinion that claimant's symptoms had no physical basis.

Finally, we find that there is no medical evidence to support claimant's contention that he suffers from a chronic condition limiting repetitive use of his neck.

Therefore, having found that claimant failed to prove any impairment due to his injuries, we conclude that claimant is not entitled to unscheduled permanent partial disability benefits.

ORDER

The Referee's order dated September 10, 1991 is affirmed.

In the Matter of the Compensation of
JACK L. ROACH, Claimant
WCB Case No. 91-08554
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
Daryll E. Klein, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Menashe's order that increased claimant's unscheduled permanent disability award for a back injury from 17 percent (54.4 degrees), as awarded by a Determination Order, to 20 percent (64 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 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).

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). 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. The rules in effect on the date of the Notice of Closure or Determination Order control. OAR 438-10-010(2); OAR 436-35-003(1); former OAR 436-35-003 & former OAR 436-35-003. In this case, the applicable rules are those in effect on February 28, 1991, the date the Determination Order issued.

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.

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.

Here, the parties stipulated that the value for age and education is 5. Also, the parties do not dispute the impairment value of 5 percent as determined by the Referee. Thus, only the adaptability value is at issue.

The Referee found that the employer had made a valid modified work offer. On that basis, the Referee determined claimant's adaptability value by comparing the physical capacity necessary to perform his regular work with that necessary to perform the modified work. Former OAR 436-35-310(3). In finding that the employer made a valid modified work offer, the Referee determined that, for adaptability purposes, there is no requirement that the modified work offer be approved by the attending physician. We disagree.

Former OAR 436-35-270(3)(d) provides that "'[w]ork offer:' as used in OAR 436-35-290 through 436-35-310 means a written offer of employment by the employer that, in the attending physician's medical opinion[,] is within the worker's capabilities." Former OAR 436-35-310 provides the rules for determining an adaptability value. Neither the Referee nor this Board has the authority to substitute substantial compliance for strict compliance with a precisely defined rule. See e.g. Eastman v. Georgia Pacific Corp., 79 Or App 610 (1986). Consequently, in order to qualify as a modified work offer for adaptability purposes, the work offer must be approved by the attending physician.

Here, Dr. Gehling, neurosurgeon, released claimant for the modified work offered by the employer. (Ex. 16). The question is whether Dr. Gehling is claimant's attending physician. We find that he is not. Instead, we agree with the Referee that Dr. Smith is claimant's attending physician.

The insurer argues that Dr. Gehling became claimant's attending physician by his actions and those of Dr. Smith. We disagree. After claimant's back condition did not improve following conservative treatment, Dr. Smith referred him to Dr. Gehling for re-evaluation. (Ex. 4). Dr. Gehling had evaluated claimant in the past for recurrent right L-5 radiculopathy. (Ex. 6-1). Dr. Gehling examined claimant, ordered a CT scan of the lumbar spine, and informed claimant that he recommended against surgery. (Exs. 6, 8). Before approving the modified work offer, Dr. Gehling informed the insurer that: (1) he was not claimant's primary care physician; and (2) he saw claimant only in consultation. (Ex. 15). Furthermore, Dr. Gehling referred the insurer to Dr. Smith regarding any release for work. Id.

Although Dr. Smith at one point noted that Dr. Gehling was managing claimant's treatment, the record indicates that Dr. Smith remained claimant's attending physician. In fact, the insurer acknowledged his status as such by noting that Dr. Gehling saw claimant only in consultation and requesting that Dr. Smith, in his capacity as claimant's primary care physician, concur with or challenge the results of a closing examination performed by Dr. Hendricks, M.D. (Ex. 24). Dr. Smith also acknowledged his status as such in his response to the insurer's letter by concurring with Dr. Hendricks' evaluation. Id. On this record, we find that Dr. Smith is claimant's attending physician. Because Dr. Smith never approved the job offer as being within claimant's physical capacity, it is not a valid work offer for adaptability purposes.

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).

The "time of determination" is the mailing date of the Determination Order or Notice of Closure. Former OAR 436-35-005(8) (Temp). The category into which the worker's physical capacity falls is determined from the worker's actual physical capacities and the descriptions of the categories of physical capacity in former OAR 436-35-270(3)(e)-(j) (Temp). (Although the applicable "standards" make no express provision for physical capacities which fall between two categories, the table at former OAR 436-35-310(4) utilizes classifications between the defined categories). Additionally, it must be determined whether the worker has "restrictions" as provided in former OAR 436-35-310(5) (Temp).

Here, the preponderance of evidence established that claimant's physical capacity is within the medium-light category or classification. (Exs. 23-5, 24). Claimant does have "restrictions" as provided in the applicable "standards." Therefore, the appropriate adaptability value is 3.5.

Claimant did not undergo a physical capacities evaluation. (Ex. 13-2). Relying on a May 1990 report from Dr. Gehling, claimant argues that he is restricted to light-sedentary work with restrictions. (Ex. 9-2). However, this report was issued well before claimant was found medically stationary in

November 1990. Also, Dr. Smith, claimant's attending physician, concurred with Dr. Hendricks' report which establishes that claimant is restricted to medium-light work with restrictions. (Exs. 23-5, 24).

Having determined each of the values necessary under the "standards", claimant's unscheduled permanent disability may be calculated. The product of the value for claimant's age and education (5) and the value for claimant's adaptability (3.5) is 17.5. When that value is added to claimant's impairment value (5), the result is 22.5 percent unscheduled permanent partial disability. That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 23 percent.

We note that claimant argues that the record, as a whole, constitutes clear and convincing evidence that his disability is greater than that compensated by the standards. However, the 1990 amendments deleted the statutory provisions that allowed a party to establish by clear and convincing evidence that a worker's disability was less or greater than that indicated by the standards. ORS 656.283(7) and 656.295(5).

The parties are now limited to establishing "by a preponderance of the evidence that the standards adopted pursuant to ORS 656.726 for evaluation of the worker's permanent disability were incorrectly applied in the reconsideration order pursuant to ORS 656.268." ORS 656.283(7) and 656.295(5). Here, claimant succeeded in establishing by a preponderance of the evidence that the standards were incorrectly applied in the reconsideration order. As a result, his permanent disability is increased from 17 percent, as awarded by the reconsideration order, to 23 percent. However, there is no longer a statutory provision for an award of permanent disability outside of that allowed by the standards.

ORDER

The Referee's order dated October 17, 1991 is modified. In addition to the Referee's awards and Order and Reconsideration of 20 percent (64 degrees) unscheduled permanent disability claimant is awarded 3 percent (9.6 degrees) unscheduled permanent disability, giving him a total award to date of 23 percent (73.6 degrees) unscheduled permanent disability for a low back injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total attorney fees awarded by the Referee and Board orders shall not exceed $3,800.

July 23, 1992 Cite as 44 Van Natta 1521 (1992)

In the Matter of the Compensation of
RITA R. SPURGEON, Claimant
WCB Case No. 86-02697
ORDER ON REMAND
James L. Edmunson, Claimant Attorney
Miller, Nash, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Liberty Northwest Insurance Corp. v. Spurgeon, 109 Or App 566 (1991), rev den 313 Or 210 (1992). The court reversed our order which adopted a Referee's order that set aside the insurer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS). The Referee had concluded that causes of a disease that are personal to a claimant (idiopathic) 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 claimant's disease. The court reasoned that any cause of a disease, as opposed to merely a susceptibility or predisposition, must be considered in determining which, if any, was the major contributing cause. Inasmuch as the court could not tell whether we found claimant's idiopathic factors to be causes of her CTS or merely conditions that made her susceptible to CTS, the court remanded for reconsideration.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In determining the compensability of claimant's CTS, the Referee found that the clear weight of the medical evidence demonstrated that "claimant's idiopathic factors including her age, gender and borderline diabetes are a greater factor than either her on the job or off the job activities." However, the Referee concluded that, in view of prior caselaw and policy considerations, claimant's "idiopathic factors should [not] be considered in deciding whether her carpal tunnel syndrome is compensable." The Referee found the claim compensable on the basis that claimant's "work activities are a material cause of her carpal tunnel syndrome and those activities compared to her off the job activities are the major cause of her carpal tunnel syndrome." We affirmed and adopted the order of the Referee.

The Court of Appeals found that the Board's analysis "fails to take into consideration the difference between a susceptibility or predisposition to a disease and a disease that is actually caused by idiopathic factors, independently of a claimant's activities or exposures anywhere." Liberty Northwest Insurance Corp. v. Spurgeon, supra, 109 Or App at 569 (Emphasis in original). The court agreed that a claimant's predisposition to a disease was not a bar to compensability if work activities were the major contributing cause of the disease. However, the court stated that a claim would not be compensable if factors personal to the claimant that were present independent of any activities or exposures either off or on the job were the major cause of a disease. Id.

The court remanded to the Board because our order "did not distinguish between a predisposition and idiopathic causes. We cannot tell whether it found that the idiopathic factors were causes of claimant's carpal tunnel syndrome or whether they merely existed as conditions that made her susceptible to carpal tunnel syndrome." Id. at 570 (Emphasis in original). Therefore, we proceed to examine the medical evidence in compliance with the decision of the Court of Appeals.

The record contains three opinions regarding causation. Dr. Jewell, surgeon, treated claimant for her CTS. In a letter to the insurer, Dr. Jewell stated that "there is difficulty in determining what is the most likely contributing factor to [claimant's] carpal tunnel syndrome. By this, I believe that she has some form of occupational exposure, as described to me[.] * * * Additionally, [claimant] does have a component of probably endocrine basis in terms of her age and hormonal status." (Ex. 30-2).

Later, after observing claimant at her work place, Dr. Jewell stated that claimant's condition was not "totally related to her occupation" and that "there could be contribution from a variety of areas to produce her carpal tunnel syndrome." (Ex. 5-4).

Jewell reiterated this opinion in a subsequent deposition. Specifically, he stated that claimant's condition is "sort of multifactorial." (Ex. 38-12). Although Jewell found that claimant's condition was not "totally work related," he indicated "some contribution from her work activity." (Id). Other factors cited by Jewell included claimant's status as a "borderline diabetic," (id. at 14), and claimant's menopausal or postmenopausal condition, (id. at 15). Jewell rated claimant's menopausal condition as the most probable factor in the development of claimant's CTS. (Id. at 15, 18).

Dr. Mundall, neurologist, who first diagnosed claimant's CTS, reported that claimant's work activities were the most likely "contributing factor in causing her bilateral carpal tunnel syndrome." (Ex. 33). In a later report, Mundall stated that the basis of his opinion was the work history he received from claimant. (Ex. 32A).

Finally, Dr. Schroeder, orthopedic surgeon, conducted a record review and visited claimant's work site. He reported that claimant "has idiopathic carpal tunnel syndrome, which is non-industrial in origin." (Ex. 37). In testimony at hearing, Schroeder further stated that he believed that claimant's work activities were not the major contributing cause of her condition because, although repetitive, her duties were diverse. (Tr. 47-48). Schroeder further stated that "the major problem was the idiopathic carpal tunnel syndrome. There may have been some aggravation with her job, but the major contributing factor was probably based on idiopathic changes." (Id. at 52-53). Schroeder identified the "idiopathic changes" as claimant's diabetic condition and menopausal age. (Id. at 49).

In weighing conflicting evidence, we give more weight to those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). Here,

Drs. Jewell and Schroeder demonstrated a complete knowledge of claimant's work activities and condition; both physicians visited the work site and provided well-reasoned explanations to support their opinions. Dr. Mundall, on the contrary, stated that his knowledge of claimant's work activities was based solely on claimant's history; moreover, his opinion was conclusory and without explanation. See Moe v. Ceiling System, 44 Or App 429, 433 (1980). Therefore, we give greater weight to the opinions of Drs. Jewell and Schroeder.

As described above, Jewell and Schroeder found that claimant's "idiopathic" factors, including her borderline diabetes and menopausal condition, contributed to her CTS. Neither doctor, however, explicitly labels these "idiopathic" factors as causes or susceptibilities. However, in the context of their entire statements, we find that it is more reasonable to interpret their opinions as indicating that these factors caused claimant's CTS. For instance, in his deposition, Dr. Jewell stated that claimant was "sort of a subset of many different things that we've discussed here, as far as causation. We've talked about her middle age, being in the middle age, and being menopausal. We've talked about a certain work contribution, and there could be even an idiopathic contribution." (Ex. 38-16) (Emphasis added). Later, Jewell states that "there is a component of job contribution but I think the development of her carpal tunnel is from a variety of factors, not just pure occupational etiology." (Id. at 18) (Emphasis added). At hearing, Dr. Schroeder stated that "the major contributing factor [to claimant's CTS] was probably based on idiopathic changes." (Tr. at 52-53).

Having found that the idiopathic factors were causes of claimant's CTS, we include them in our consideration of determining the major cause of claimant's condition. See Liberty Northwest Insurance Corp. v. Spurgeon, supra. As explained above, we interpret the opinions of both Drs. Jewell and Schroeder as indicating that claimant's work was not the major contributing cause of her CTS and that it was only one factor in the development of her condition. Therefore, we conclude that claimant failed to prove the compensability of her claim. See Dethlefs v. Hyster Co., 295 Or 298, 310 (1983).

Accordingly, on reconsideration, the Referee's order dated June 11, 1987 is reversed. The insurer's denial is reinstated and upheld. The Referee's attorney fee award is reversed.

IT IS SO ORDERED.

July 23, 1992 Cite as 44 Van Natta 1523 (1992)

In the Matter of the Compensation of
JILL C. VAN HORN, Claimant
WCB Case No. 91-06712
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Tooze, Shenker, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of that portion of Referee Peterson's order that increased claimant's scheduled permanent disability award for a left ankle/foot condition from 3 percent (4.05 degrees), as awarded by an Order on Reconsideration, to 8 percent (10.8 degrees). In her brief, claimant argues that the Board should not consider the insurer's contention that the award should be reduced, because that issue was not raised before the Referee. On review, the issues are scope of review and extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Scope of review

Claimant argues that the Board should not consider the insurer's contention that her permanent disability award should be reduced, because that issue was not raised before the Referee. Claimant

relies on Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991). In Stevenson, the court decided that the Board properly refused to address an issue not adequately raised before the Referee. (Id). Here, however, claimant's request for hearing raised the extent of permanent disability issue and the insurer's written response asserted that claimant is not entitled to "additional" permanent disability. At the time of the hearing request, claimant's award (as provided by an Order on Reconsideration) was 3 percent scheduled permanent disability. Under these circumstances, we find that the issue of permanent disability compensation, beyond the 3 percent award, was before the Referee. See Liberty Northwest Ins. Corp. v. Alonzo, 105 Or App 458 (1991). Pursuant to the insurer's request for review, the issue is properly presented on Board review.

Extent of scheduled 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 August 6, 1990 and her claim was closed by Determination Order on January 2, 1991. 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. Former OAR 436-35-010 through 436-35-260, as amended by temporary rules in effect at the time of closure, apply to the rating of claimant's scheduled permanent disability. See WCD Admin. Orders 7-1988 (see also WCD Admin. Order 1-1989), 15-1990 & 20-1990.

The Referee found claimant to be entitled to scheduled permanent disability ratings of 5 percent for a chronic condition which limits repetitive use of the left ankle/foot and 3 percent for peroneal weakness, for a total award of 8 percent scheduled permanent disability.

The insurer contends that claimant is not entitled to an award for a chronic left ankle condition, because the medical evidence does not establish that she is unable to repetitively use that body part. See former OAR 436-35-010(8) (WCD Admin. Orders 15-1990 & 20-1990 (temp.)). The insurer correctly observes that any finding of fact regarding a worker's impairment must be established by medical evidence supported by objective findings. See ORS 656.283(7); 656.295(5); 656.726(3)(f)(B). William K. Nesvold, 43 Van Natta 2767 (1991).

On July 16, 1990, Dr. Bald, treating physician, reported that claimant "has difficulty ambulating for long periods of time -- even in the ankle brace." (Ex. 36). Dr. Bald described claimant's left ankle condition as a "chronic lateral ligament sprain" on August 6, 1990, claimant's medically stationary date. (Ex. 37). Claimant testified that she is unable to walk more than five or ten minutes without having to sit down, due to ankle pain. (Tr. 6-8). The question is whether this evidence is sufficient to support a permanent disability award for a chronic condition limiting the repetitive use of claimant's left ankle. We conclude that it is not.

We acknowledge claimant's testimony regarding her continuing pain with walking. However, although the medical evidence reflects claimant's complaints that her ankle pain is worse with activity, examining and treating physicians urge claimant to exercise her ankle regularly. (See Exs. 6, 8, 9, 10, 11, 12, 13, 17, 23, 27, 36, 37, 38). Moreover, Dr. Bald opined that claimant's "only chance of subjectively improving is with a vigorous exercise program." (Ex. 38-2). On September 24, 1990, Bald "did not foresee any situation under which [claimant] would not be capable of working on a full-time regular duty basis." (Ex. 38-1). Claimant's job as a shelf-stocker is a "standing occupation." (Ex. 22-2). Drs. Skei and Staver opined that claimant "needs to stop favoring and start using her ankle to avoid perpetuation of a chronic pain syndrome. Her brace should only be used when she is going to be walking on uneven ground." (Ex. 27-4). Recommended exercises have included "full range of motion" (Ex. 6), swimming and cycling (Exs. 12, 13, 27-4), isometric peroneal strengthening exercises (Ex. 17, 23), and stretching exercises with surgical tubing (Ex. 36). Dr. Bald opined that an ongoing exercise program should result in a decrease in claimant's subjective complaints, though it would not likely improve her objective examination. (Ex. 38, 42). No physician has restricted claimant's walking since July 12, 1989, over a year before claimant became medically stationary. (See Ex. 9). Under these circumstances, we

conclude that a preponderance of the medical opinion does not establish that claimant is unable to repetitively use her left ankle due to her chronic and permanent left ankle condition, as required by former OAR 436-35-010(8). See Kathleen A. Hoff, 43 Van Natta 2620, 2621 (1991).

The insurer does not challenge claimant's 3 percent award for peroneal weakness. Accordingly, that award is not evaluated.

ORDER

The Referee's order dated September 10, 1991 is reversed. The Order on Reconsideration award of 3 per cent (4.05 degrees) scheduled permanent disability for the left ankle/foot is affirmed.

In the Matter of the Compensation of
KEVIN W. WATERS, Claimant
WCB Case No. 91-04983
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of that portion of Referee Nichols' order that directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree. Claimant has cross-requested review, requesting penalties and attorney fees for the insurer's failure to pay claimant's scheduled disability award at $305 per degree and an increase in claimant's unscheduled permanent disability award. On review, the issues are rate of scheduled permanent disability, extent of unscheduled permanent 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

Rate of Scheduled Disability

The Referee concluded that claimant's award of scheduled permanent disability should be paid at the rate of $305 per degree. The Referee relied on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), in which we held that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. Subsequent to the Referee's order, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992).

In this case, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury. ORS 656.202(2); Former ORS 656.214(2).

Unscheduled Permanent Disability

We adopt the conclusions and reasoning concerning the extent of unscheduled permanent disability issue as set forth in the Referee's order with the following note.

Claimant requests that we increase his unscheduled disability award based on Dr. Mayhall's November 13, 1990 report. In that report, Dr. Mayhall addresses permanent impairment to claimant's back. He states:

> "According to my exam of 7/13/90, this patient would receive a 1% loss based on extension. He had no loss based on rotational motions. In addition, I must comment that clinically, his flexion and extension are so close to normal that his 'impairment' has to be taken advisedly * * *"

Dr. Mayhall bases his impairment findings for claimant's back on findings he made on July 13, 1990. On that date, Dr. Mayhall reported that claimant was not medically stationary with regard to his back. Accordingly, we decline to rely on those findings, made before claimant was medically stationary, to rate claimant's impairment.

Penalties and Attorney Fees

We adopt the reasoning and conclusion on the penalty and attorney fee issue as set forth in the Referee's order.

ORDER

The Referee's order dated November 29, 1991 is reversed in part and affirmed in part. That portion of the Referee's order which directed the insurer to pay claimant's scheduled disability award at $305 per degree is reversed. The remainder of the Referee's order is affirmed.

July 24, 1992 Cite as 44 Van Natta 1526 (1992)

In the Matter of the Compensation of
JOANN FRYMAN, Claimant
WCB Case Nos. 88-05650, 88-10554, 88-10557 & 88-10556
ORDER ON RECONSIDERATION
Karen M. Werner, Claimant Attorney
Cowling & Heysell, Defense Attorneys

On July 7, 1992, we withdrew our June 9, 1992 Order on Remand which had republished our September 26, 1990 order that set aside the insurer's denial of claimant's occupational disease claim for her low back condition. We took this action to consider claimant's contention that her attorney was entitled to a fee pursuant to ORS 656.388(1) for services rendered before the Court of Appeals. In response, the insurer states that it does not contest claimant's request.

Inasmuch as claimant has finally prevailed after remand, she is entitled to an attorney fee for services rendered before all prior forums. ORS 656.388(1). Claimant has already been awarded a $3,000 carrier-paid attorney fee for services at the hearing and on Board review concerning the compensability of her occupational disease claim. Consequently, in addition to that award, we grant claimant an attorney fee for services performed at the Court of Appeals.

After considering the factors set forth in OAR 438-15-101(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services before the Court of Appeals is $750, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as evidenced by claimant's counsel's affidavit), the complexity of the issue, and the value of the interest involved.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our July 7, 1992 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
MARY A. DYER, Claimant
WCB Case No. 91-12898
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

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 January 12, 1989, claimant sustained a compensable injury to her low back. Her claim was closed by a March 7, 1991 Notice of Closure which awarded no unscheduled permanent disability.

On July 19, 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 December 19, 1991, setting aside the Order on Reconsideration as invalid and remanding this matter to the Appellate Unit. Claimant requested Board review on December 31, 1991. On January 2, 1991, the self-insured employer moved for dismissal of claimant's request for Board review on the basis that the Referee's order was not a final appealable order. We denied the employer's motion on January 14, 1992, concluding that the Referee's order was a final appealable order and that, consequently, we had authority to consider the matters raised by claimant's request for Board review.

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 and be considered by the Department 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 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 set forth in ORS 656.268(7), 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. See Mickey L. Platz, 44 Van Natta 1056 (1992). 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 December 19, 1991, as modified herein, is affirmed.

In the Matter of the Compensation of
ROBERT E. BUCKLES, Claimant
WCB Case No. 91-03272
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Nichols' order that: (1) found that medical treatment requested by claimant's treating physician was "palliative"; and (2) dismissed claimant's request for hearing for lack of jurisdiction. On review, the issue is jurisdiction. We vacate in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has a compensable back injury and was declared medically stationary in March 1990. Claimant's treating physician, Dr. Stringham, requested authorization from the SAIF Corporation to refer claimant for evaluation to a back rehabilitation program at Salem Hospital. After failing to receive any response regarding the authorization, claimant requested a hearing, asserting that the evaluation was compensable. Dr. Stringham did not request approval from the Director for the proposed evaluation. Review by the Director of the medical treatment under ORS 656.327 was not requested.

The Referee found that, based on the medical evidence, the proposed evaluation qualified as palliative, rather than curative, care. Based on ORS 656.245(1), the Referee found that she was without jurisdiction to address the compensability of the proposed treatment since Dr. Stringham failed to request authorization from the Director. Alternatively, the Referee concluded that "[e]ven if this evaluation were not considered to be palliative care, ORS 656.327 would require the Director to address this issue before the Board would have jurisdiction in the matter."

In Stanley Meyers, 43 Van Natta 2643, 2645 (1991), we construed ORS 656.327(1)(a) and (2), 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.

More recently, we addressed our jurisdiction to consider whether or not a claimant's medical treatment is palliative, thereby rendering such treatment 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 the characterization of medical treatment as palliative or curative generally concerned the effectiveness and appropriateness of such medical treatment. Id. at 908. Therefore, relying on Stanley Meyers, supra, we concluded that original jurisdiction of such a dispute lay exclusively with the Director under ORS 656.327. Id.

The dispute at issue here concerns whether or not the proposed evaluation is palliative or curative. Based on our holding in Gladys M. Theodore, supra, we find that original jurisdiction of the matter lies exclusively with the Director. The Referee therefore lacked jurisdiction to determine that the proposed evaluation qualified as palliative care and we vacate that portion of her order. However, the Referee correctly dismissed the request for hearing on the ground that ORS 656.327 placed original jurisdiction of the dispute with the Director.

ORDER

The Referee's order dated October 23, 1991 is vacated in part and affirmed in part. That portion of the order concluding that a proposed evaluation constituted palliative care is vacated. The remainder of the Referee's order is affirmed.

July 21, 1992 Cite as 44 Van Natta 1529 (1992)

In the Matter of the Compensation of
JESUS R. CORONA, Claimant
WCB Case No. 91-10031
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Daryl Nelson, Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Crumme's order that dismissed claimant's request for hearing concerning penalties and attorney fees for lack of jurisdiction. On review, the issues are jurisdiction and penalties and attorney fees.

We affirm and adopt the order of the Referee with the following correction and supplementation. Rather than on July 30, 1981, claimant filed his Request for Hearing on July 30, 1991. The hearing was held on October 25, 1991, and the Opinion and Order issued on November 4, 1991.

We take administrative notice that the Director issued a "Proposed and Final Order Assessing Penalty of an Additional Amount Pursuant to ORS 656.262(10)" on January 13, 1992, which awarded claimant a penalty for the insurer's late payment of temporary disability compensation, half payable to claimant's counsel as an attorney fee.

ORDER

The Referee's order dated November 4, 1991 is affirmed.

In the Matter of the Compensation of
FRED W. KREAMIER, Claimant
Own Motion No. 92-0368M
OWN MOTION ORDER
Welch, et al., Claimant Attorneys
The Travelers Insurance, Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for his compensable left knee injury. Claimant's aggravation rights expired on January 6, 1981. The insurer opposes the 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. We are persuaded that claimant's compensable injury has worsened requiring surgery.

However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

Inasmuch as claimant has submitted evidence that he was receiving temporary disability compensation under a 1987 compensable injury claim for a back surgery until January 21, 1992, we conclude that he remains in the work force.

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning April 15, 1992, the date he was hospitalized for surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-12-055.

IT IS SO ORDERED.

In the Matter of the Compensation of
PAMELA E. FLEISCHER, Claimant
WCB Case Nos. 91-06499 & 91-02287
ORDER ON RECONSIDERATION
Craine & Love, Claimant Attorneys
Schwabe, et al., Defense Attorneys
Michael O. Whitty (Saif), Defense Attorney

Claimant requests reconsideration of our June 30, 1992 Order on Review. In that order, we considered the compensability of claimant's injuries resulting from an attempted sexual assault that occurred in the morning while claimant was entering her place of employment. We found that claimant had failed to prove a sufficient "work connection" between her injuries and employment; specifically, we concluded that claimant did not establish that the work environment appreciably increased the risk of attack or that the assault was motivated by any factors related to claimant's job. Therefore, we concluded that the injuries resulting from the assault were not compensable.

Claimant urges that we allow reconsideration on the basis that it is an "extremely significant case" because of the effect on workers "who are injured at work through circumstances that are not motivated by any factor directly related to the worker's employment" and because the Board required claimant to prove a greater likelihood of assault to establish compensability.

We agree that our holding is of potential importance to workers who are injured in circumstances such as claimant's. However, after carefully reviewing claimant's request for reconsideration, we find no basis for altering our decision that claimant's claim is not sufficiently related to work to render it compensable. Claimant states that she will file an appeal with the Court of Appeals. Therefore, we leave it to the court to determine if our application of the facts to the law is incorrect. See ORS 183.482(8)(a).

Consequently, claimant's request for reconsideration is granted. Our June 30, 1992 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our June 30, 1992 order. The parties' rights of appeal shall run from the date this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD F. HOWARTH, Claimant
WCB Case No. 91-12789
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Katheryn Alvey (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig

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

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had proved that employment conditions were the major contributing cause of his disc herniation. See ORS 656.802. SAIF challenges that conclusion, asserting that the record contains insufficient medical evidence demonstrating that work conditions at its insured, as opposed to prior employers, contributed to the disc herniation. In response, claimant argues that,

pursuant to ORS 656.308(2), SAIF is precluded from avoiding responsibility for the claim on such a basis. We agree that SAIF may not raise such a defense. Because SAIF did not give notice that it intended to disclaim responsibility for claimant's condition on the basis of exposure with other employers, it is precluded from defending this claim on the basis of claimant's prior employment exposures. ORS 656.308(2). With this in mind, we turn to the merits of the claim.

The record contains two opinions concerning causation. Dr. Peterson, neurologist, who evaluated claimant during an independent medical examination, found "radiographic evidence that there was pre-existing underlying degenerative disc disease of the lumbar spine", as well as a disc herniation, and that "it would be extremely unusual for a disc herniation of this degree to have occurred spontaneously." (Ex. 16-1). However, because of the absence in claimant's history of an injurious event, Dr. Peterson stated that "we simply have not sufficient medical evidence to make a clear determination of major contributing cause. While I could speculate that on-the-job activities caused the disc herniation, it would be equally plausible to speculate that off-the-job activities caused it; and in the absence of adequate clinical history, this determination simply cannot be made." (Id. at 2).

Dr. Wayson, neurologist, claimant's treating physician, performed surgery for claimant's ruptured disc. Her opinion concerning causation consisted of one sentence: "[Claimant] has been employed in the construction industry for a number of years and I feel it is the major contributing cause to his disc herniation." (Ex. 18).

When 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 610, 614 (1983). Here, we find persuasive reasons not to give greater weight to Dr. Wayson's opinion. First, other than stating that claimant worked "in the construction industry for a number of years," Dr. Wayson does not demonstrate any knowledge of claimant's particular work duties. Furthermore, she provides no reasoning to support her conclusion. In particular, she does not discuss the significance of claimant's preexisting degenerative condition. In short, Wayson's opinion is neither well-reasoned nor proved to be based on complete information and therefore is not entitled to greater weight. See Somers v. SAIF, 77 Or App 259 (1986).

Because we find that Dr. Wayson's opinion does not outweigh the opinion of Dr. Peterson, we conclude that claimant failed to carry his burden of proof showing that employment conditions were the major contributing cause of his disc herniation and, thus, his claim fails.

ORDER

The Referee's order dated November 12, 1991 is reversed. The SAIF Corporation's denial is reinstated and upheld. The Referee's attorney fee award of $2,500 is reversed.

In the Matter of the Compensation of
JERRY B. MATHEL, Claimant
WCB Case No. 90-18752
ORDER ON RECONSIDERATION
Rasmussen & Henry, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

The self-insured employer has requested reconsideration of our June 5, 1992 Order on Review that affirmed the Referee's order setting aside the insurer's denial of claimant's myocardial infarction claim. On July 6, 1992, we abated our order to allow claimant an opportunity to respond. Claimant's response has been received.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW

Our previous order found that the claim properly was analyzed as one for an accidental injury. Jerry B. Mathel, 44 Van Natta 1113, 1114 (1992). Noting that claimant's myocardial infarction was caused by a discrete period of job stress, we found that his condition was sudden and unexpected. Id. Moreover, we concluded that, based on claimant's treating physician's unrebutted opinion, claimant proved that his work activities were a material contributing cause of his heart attack and, therefore, his claim was compensable. Id.

Subsequent to our order, the Court of Appeals issued the decision in SAIF v. Hukari, 113 Or App 475 (1992). The court found that the inclusion of the term "mental condition" in the 1987 amendments to ORS 656.802(2) (now numbered 656.802(3)):

> "was intended to encompass all claims for mental or physical disorders arising from job stress. By specifically including mental disorders in the definition of occupational disease, the legislature made clear its intent that any claim that a condition is independently compensable because it was caused by on-the-job stress, regardless of the suddenness of onset or the unexpected nature of the condition, and regardless of whether the condition is mental or physical, must be treated as a claim for an occupational disease under ORS 656.802." Id. at 480 (Emphasis in original).

The court distinguished this holding from consequential claims that are a result of a compensable injury, emphasizing that such claims are not subject to ORS 656.802. Id.

On reconsideration, the employer asserts that Hukari is applicable to this case and requests that we analyze compensability under ORS 656.802. We agree with the employer. We first note that the court analyzed the 1987 amendments to ORS 656.802, and that this case falls under the current law, as amended by the 1990 Special Session of the legislature. Nevertheless, we conclude that the holding in Hukari is equally applicable to the current version of ORS 656.802 in that the 1990 amendments to ORS 656.802(1)(b) and 656.802(3) were minor and did not affect the definition of "mental disorder." Moreover, claimant asserts that job stress caused his hypertension, which in turn resulted in a heart attack. Claimant, therefore, is seeking to establish an independent, rather than a consequential, claim. Therefore, under Hukari, claimant must prove compensability pursuant to ORS 656.802(1)(b) and 656.802(3).

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 by way of medical evidence supported by objective findings. ORS 656.802(2). Additionally, there must be a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community. ORS 656.802(3)(c).

We conclude that, in the absence of a diagnosed mental disorder, the present claim must fail. "Stress," in and of itself, is not a condition which is generally recognized as a mental disorder. See Ronald V. Dickson, 42 Van Natta 1102, 1108, aff'd 108 Or App 499 (1991). The record is devoid of any diagnosis that satisfies ORS 656.802(3)(c). Without such a diagnosis, we conclude that claimant failed to establish compensability of his claim.

Accordingly, our June 5, 1991 Order on Review is withdrawn. On reconsideration, we reverse the Referee's order dated April 30, 1991, as reconsidered on July 12, 1991, as well as the Referee's award of $5,300 as an assessed attorney fee. The employer's denial is reinstated and upheld. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
TIMOTHY W. REINTZELL, Claimant
WCB Case No. 91-06946
ORDER ON REVIEW
Max Rae, Claimant Attorney
David O. Horne, Defense Attorney

Reviewed by Board Members Gunn and Moller.

The insurer requests review of that portion of Referee Nichols' order which directed it to pay claimant's scheduled permanent disability awards made in the May 1991 Order on Reconsideration at the rate of $305 per degree. Claimant cross-requests review of the same issue, contending that the insurer should pay the scheduled permanent disability awards made in the December 1990 Determination Order at the rate of $305 per degree as well. Claimant also requests review of that portion of the Referee's order which affirmed the scheduled permanent disability award of 11 percent (21.12 degrees) for the left arm, made in the Order on Reconsideration. On review, the issues are rate of scheduled permanent disability and extent of permanent disability. We modify in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Disability

The Referee affirmed the May 1991 Order on Reconsideration, which reduced claimant's scheduled permanent disability award for the loss of use or function of the left arm from 25 percent, as awarded in the December 1990 Determination Order, to 11 percent. The Referee relied on the medical arbiter's finding that claimant had no loss of grip strength in the left arm. The Determination Order award had included impairment due to loss of grip strength. (Cf. Exs. 5-4 and 6-2 with Exs. 2-2, 3, and 4-3).

The Referee relied on the medical arbiter's findings because the standards in effect at the time of the Determination Order provided that, when the impairment findings of the medical arbiter and attending physician differ, "the findings of the arbiter shall be used to determine impairment under these rules." Former OAR 436-35-007(9) (emphasis added) (WCD Admin. Orders 6-1988, 15-1990, and 20-1990). The permanent standards, adopted March 26, 1991 and effective April 1, 1991, provide that "[o]n reconsideration, where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment." OAR 436-35-007(9) (WCD Admin. Order 2-1991).

Claimant contends that his impairment should be established by a preponderance of the evidence, rather than by exclusive reliance on the medical arbiter's findings, despite the express language of former OAR 436-35-007(9). Claimant further contends that the preponderance of the evidence establishes that he retains only 60 percent of his left forearm grip strength, based on the measurements of his treating doctor, Dr. Becker. Therefore, claimant argues that under former OAR 436-35-110(3)(d), he is entitled to a rating of 20 percent impairment for decreased grip strength in the left arm. We agree.

Because claimant last became medically stationary after July 1, 1990, we apply the workers' compensation law as amended by the Legislature on May 7, 1990. See Or Laws 1990, Ch. 2, Sec. 54(3).

For purposes of determining injury-related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the "standards" for the evaluation of disabilities adopted by the director pursuant to ORS 656.726(3)(f)(A). Those "standards" in effect on the date of the issuance of the Determination Order control the evaluation of permanent partial disability at hearing and on review of the reconsideration order. OAR 438-10-010(2) (WCB Admin. Order 4-1991, temporary rule, effective June 17, 1991).

The Director is charged with providing standards for evaluating disabilities. ORS 656.726(3)(f). The statute further provides that under the standards, "[i]mpairment is established by a preponderance of medical evidence based upon objective findings." ORS 656.726(3)(f)(B).

Upon reconsideration of a determination order, when a medical arbiter is appointed, ORS 656.268(7) provides that the medical arbiter's findings shall be submitted to the department for reconsideration of the Determination Order, 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."

"Administrative rules must be consistent with an agency's statutory authority. The agency may not alter, amend, enlarge or limit the terms of an applicable statute by rule." Harrison v. Taylor Lumber & Treating, Inc., 111 Or App 325, 328 (1992), citing Cook v. Workers' Compensation Department, 306 Or 134, 138 (1988).We find that the Director's rule which mandated that impairment shall be established only by the medical arbiter's findings is inconsistent with the statutory directive that impairment is to be established under the standards by a preponderance of the medical evidence. Compare former OAR 436-35-007(9) with ORS 656.726(3)(f)(B). We also find that the Director's rule is inconsistent with ORS 656.268(7) which provides only that the medical arbiter's findings shall be submitted to the Department, and that no subsequent medical evidence of impairment shall be considered. The statute does not mandate that only the medical arbiter's findings shall be used to establish impairment. Moreover, we note that the Director apparently recognized the inconsistency as well, since the permanent rule, effective April 1, 1991, provides that the medical arbiter's findings shall establish impairment, except where the preponderance of medical evidence establishes a different level of impairment. See OAR 436-35-007(9) (WCD Admin. Order 2-1991).

Accordingly, because we find that former OAR 436-35-007(9) is inconsistent with the applicable statutes, we give it no effect. Instead, consistent with our interpretation of ORS 656.726(3)(f)(B) and 656.268(7), we determine what level of impairment is established by the preponderance of medical evidence, considering the medical arbiter's findings and any prior impairment findings.

Dr. Mayhall, the medical arbiter appointed by the Director, examined claimant and found that "[g]rip on the right and left were equal on clinical testing." (Ex. 5-4). Based on this finding, the Director concluded that "claimant is not entitled to an award for decreased grip strength." (Ex. 6-2). However, Dr. Mayhall also found evidence of "a very mild amount of atrophy of the left forearm," which he found to be consistent with claimant's fracture, casting, and the clinical course of his injury. (Ex. 5-5). Claimant testified that Dr. Mayhall did not conduct a test measuring his grip strength. (Tr. 14).

Dr. Becker, claimant's treating physician, conducted a closing examination on October 3, 1990, in which he measured claimant's grip strength: "Grip testing was measured at 110/65 lbs., and later in the exam in a blind fashion measured at 115/65 lbs. Maximal effort was felt to be applied." (Ex. 2-2). Dr. Becker commented that the test had been "quite reproducible," thereby lending to claimant's credibility. He explained that the left arm measurement represents a 40 percent loss in strength. (Ex. 3). Based on Dr. Becker's findings, claimant was awarded 20 percent impairment by the December 1990 Determination Order due to left forearm weakness. (Ex. 4-3).

We find Dr. Becker's grip strength measurements to be more persuasive. Dr. Becker actually tested and measured claimant's grip strength in both arms and verified his findings with a subsequent "blind" test. Becker observed that the test was reproducible, and that claimant had applied maximal effort. Dr. Mayhall, on the other hand, did not measure claimant's grip strength, but simply opined that grip was equal on clinical testing. Nevertheless, Dr. Mayhall also found a mild amount of atrophy, a finding which is consistent with Dr. Becker's measurements.

Under these circumstances, we rely on Dr. Becker's measurements, and conclude that claimant has 40 percent loss of grip strength in his left forearm. We find that this loss is due to atrophy, based on Dr. Mayhall's observation, which we find to be consistent with Dr. Becker's measurements. Under the standards in effect in December 1990, a 40 percent loss of grip strength yields 20 percent impairment for weakness of the left forearm. Former OAR 436-35-110(3)(d) (WCD Admin. Order 6-1988, effective January 1, 1989). This is the impairment value used in rating claimant's disability under the December

1990 Determination Order. (Ex. 4-3). Accordingly, we find that claimant is entitled to a scheduled permanent disability award of 25 percent (48 degrees) for loss of use or function of his left arm.

Rate of Scheduled Permanent Disability

The Referee concluded that claimant's award of scheduled permanent disability made in the Order on Reconsideration should be paid at the rate of $305 per degree. The Referee relied on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), in which we held that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. Subsequent to the Referee's order, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (July 8, 1992).

In this case, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury. ORS 656.202(2); Former ORS 656.214(2). Accordingly, we reverse that portion of the Referee's order that ordered claimant's scheduled permanent disability award made in the Order on Reconsideration to be paid at the rate of $305 per degree.

Offset

In light of our conclusion that claimant is entitled to a scheduled permanent disability award of 25 percent (48 degrees) for loss of use or function of his left arm, the Referee's authorization to offset the "overpaid" permanent disability paid pursuant to the Determination Order against the "increased rate" of scheduled permanent disability is reversed.

ORDER

The Referee's order dated September 16, 1991 is modified in part and reversed in part. In addition to claimant's prior award of 11 percent (21.12 degrees) scheduled permanent disability award for his left arm, claimant is awarded 14 percent (26.88 degrees), for a total award to date of 25 percent (48 degrees) for loss of use or function of the left arm. That portion of the Referee's order that ordered claimant's scheduled permanent disability award to be paid at the rate of $305 per degree is reversed. Instead, claimant's entire scheduled permanent disability award shall be paid at the rate of $145 per degree. The Referee's offset authorization is reversed. Claimant's attorney is awarded a fee of 25 percent of the increased compensation created by this order, not to exceed a total of $3,800 in fees approved by the Referee and the Board orders.

In the Matter of the Compensation of
DONALD S. WADE, Claimant
WCB Case No. 91-00005
ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

The SAIF Corporation requests reconsideration and abatement of our June 29, 1992 Order on Review. In that order, we determined that SAIF was required under former OAR 438-17-015 to disclose its investigator's notes summarizing statements of two of claimant's co-workers and assessed a penalty for SAIF's failure to disclose the notes. In its request, SAIF asserts that our order "has called into doubt whether the Board recognizes" the attorney-client and work product privileges. Furthermore, SAIF contends that its investigator's notes fall under the work product privilege and therefore are not subject to discovery under former OAR 438-17-015.

In order to consider SAIF's motion, we withdraw our June 29, 1992 order. Claimant is granted an opportunity to respond by submitting a response 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
PAZ A. CASAS, Claimant
WCB Case Nos. 91-01604 & 90-16437
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Carrol Smith (Saif), Defense Attorney

Reviewed by Board Members Brazeau, Kinsley, and Hooton.

Claimant requests review of that portion of Referee Tenenbaum's order that upheld the SAIF Corporation's partial denial of her claim for a left shoulder condition. On review, the issue is compensability of medical services.

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

Claimant's history that her left shoulder problems began soon after the May 1, 1990 incident is inconsistent with Dr. Baum's September 17, 1990 chart note, which includes no reference to left shoulder problems, but, instead, reports normal range of left shoulder motion.

ORDER

The Referee's order dated June 28, 1991 is affirmed.

Board Member Hooton dissenting.

Because we conclude that the claimant's abdominal hernia is compensable, and accept the causal theory offered by Dr. Brant, I would find claimant's left shoulder condition compensable as well.

Claimant's abdominal hernia is compensable only if the force she exerted in extricating her left hand from the pizza sealing machine was sufficient to produce a tear of the abdominal musculature at the umbilicus. We have found that to be the case. However, all of the force that was generated in that effort was directed through claimant's left shoulder, elbow, wrist and hand. If that force was great enough to tear the muscles of the abdomen, a site far removed from the left upper extremity, it must also have been great enough to have caused the left shoulder strain diagnosed by the Western Medical Consultants.

I find that the opinion expressed by the Western Medical Consultants is consistent with claimant's testimony and the probable mechanism of injury. In finding the condition not compensable the majority requires the medical experts to draft reports with greater particularity and care than is usually required in the medical sciences. That requirement is both incorrect and unreasonable.

Further, I disagree with the majority that Dr. Baum's failure to note shoulder symptoms in his September 17, 1990 chart is dispositive of the claim. While the chart note on that date does not reference shoulder pain, the subsequent chart note of October 10, 1990 states that "[claimant] has continued to work with aggravating pain at the left shoulder now worse than the left hand..." (Ex. 11). That chart note indicates the continuation and worsening of symptoms in the left shoulder from the prior exam and clearly indicates the presence of shoulder symptoms on September 17, 1990, even though those symptoms were not reported in the chart notes of that date.

I would find the left shoulder condition to be compensable. The mechanism of injury and the medical evidence requires that finding. Therefore, I dissent.

In the Matter of the Compensation of
ARTHUR HOOPER, Claimant
WCB Case No. 91-06805
ORDER ON REVIEW
William Skalak, Claimant Attorney
Susan Ebner (Saif), Defense Attorney

Reviewed by Board Members Kinsley, Brazeau, and Hooton.

The SAIF Corporation requests review of that portion of Referee Peterson's order that set aside its "de facto" denial of claimant's aggravation claim for an upper back condition. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The issue presented is whether claimant has established a compensable aggravation of his upper back condition. 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 law as amended by the 1990 Legislature. Or Laws 1990 (Special Session), ch. 2, §54; Ida M. Walker, 43 Van Natta 1402 (1991).

Under the current version of ORS 656.273(1), an injured worker remains entitled to compensation for a "worsened condition" resulting from the compensable injury since the last arrangement or award of compensation. Furthermore, the traditional definition of a "worsened condition," i.e., an increase in symptoms or a pathological change resulting in diminished earning capacity, remains intact. Leroy Frank, 43 Van Natta 1950 (1991). The worsened condition, however, must be established by medical evidence supported by objective findings. ORS 656.273(1).

In this case, claimant contends that his upper back condition worsened in December 1990. He relies on the opinion of his treating physician, Dr. Jackson, who, on December 27, 1990, reported:

> "[Claimant] has had a worsening of his neck and upper back condition. He is not medically stationary at this time. He has not been able to do physical therapy since around September.
>
> "Today on examination he had objective findings that included decrease in range of motion of his neck and upper back, especially in left lateral extension, which is limited at least 25%. The neck and upper back muscles are tight and in spasm." (Ex. 11).

SAIF cites no medical evidence to rebut Dr. Jackson's report. Rather, it contends that the report is insufficient to establish a worsening, because claimant "repeatedly suffered episodes of decreased range-of-motion and spasm, both before and after he was determined medically stationary." (App. brief at 2).

However, while Dr. Jackson noted in his closing report that claimant continued to have some discomfort and stiffness in his thoracic and cervical spine, he also reported that claimant was "essentially medically stationary" and that claimant "has no restrictions in his work because of the neck and upper back condition." (Ex. 9). In contrast, Dr. Jackson subsequently reported that claimant was "not medically stationary" and had incurred a substantial period of disability as a result of a worsening of his

conditions. (Exs. 11, 16). After our review and comparison of those medical reports, we conclude that claimant has established a worsening of his compensable condition.

SAIF next contends that, even if claimant's condition has worsened, there is no evidence that such a worsening has resulted in a diminishment of earning capacity. It contends that claimant was able to work as demonstrated by his work as a volunteer fireman and relies on the testimony of Assistant Fire Chief Bivins. However, Bivins did not see claimant engaged in any sort of physical activity during the time in question, except when claimant chased after his child at a company picnic. (Tr. 59). Bivins was unable to testify as to how many alarms claimant had answered, whether claimant had engaged in various drills or performed any physical strenuous activities. Moreover, claimant testified at length regarding his volunteer fireman activities and explained that most of the training exercises did not require physical work and that others he performed within his restrictions. His testimony was unrebutted and found credible by the Referee. Accordingly, we give little weight to the testimony of Bivins and, based on Dr. Jackson's time loss authorization, conclude that claimant has established a diminishment of earning capacity.

SAIF last contends that claimant has failed to establish that the worsening is causally related to his compensable injury. We disagree. The only medical evidence submitted on causation comes from Dr. Jackson, who reported:

> "It is my opinion that the worsening neck and upper back condition was the same condition, or reasonably related, to the on-the-job injury of 4-21-90 [sic], and that the 4-21-89 injury was the major contributing cause of his continued symptoms and disability in December of 1990." (Ex. 16).

Based on that opinion, and in the absence of any evidence to the contrary, we conclude that claimant has shown a causal relationship sufficient to establish a compensable aggravation of his upper back condition. The Referee's order is affirmed.

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 $1,125, 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 claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated September 11, 1991 is affirmed. For services on Board review concerning the aggravation issue, claimant's attorney is awarded an assessed fee of $1,125, to be paid by the SAIF Corporation.

Board member Hooton concurring.

While I agree with the majority resolution of this claim, so far as it goes, I write because the majority does not address arguments made by SAIF which cry out for discussion.

This case arose from claimant's May 29, 1991 request for hearing, which alleged that SAIF had de facto denied a reopening of his claim for a worsened condition. The Referee found that Dr. Jackson's December 27, 1990 report was sufficient to constitute a valid aggravation claim. The Referee concluded, however, that SAIF had accepted the claim by virtue of its February 6, 1991 authorization for treatment. On August 26, 1991, prior to hearing, SAIF formally issued a written denial of aggravation.

At the outset, I agree with SAIF's contention that its authorization for additional treatment should not be considered as an acceptance of a claim. Under ORS 656.262(9), the mere payment of compensation does not constitute the acceptance of a claim. Richmond v. SAIF, 85 Or App 444 (1987). Under the recent statutory amendments, claimant must seek authorization for palliative as well as some curative care. Under these circumstances, an authorization of medical treatment cannot, in and of itself,

constitute an acceptance of an aggravation claim. Nonetheless, I conclude that claimant has established a compensable aggravation of his upper back condition, and would, therefore, set aside both SAIF's de facto denial, and its August 26, 1991 written denial, of a compensable worsening.

In order to establish an aggravation claim, claimant must show, by medical evidence supported by objective findings, "worsened conditions resulting from the original injury." ORS 656.273(1). "Worsened conditions" means a change in condition that makes claimant more disabled, either temporarily or permanently, than he was when the original claim closed. Smith v. SAIF, 302 Or 396 (1986); John E. Means, 43 Van Natta 2331 (1991). If the major contributing cause of the worsened condition is an off-work injury, however, the worsening is not compensable. Elizabeth A. Bonar-Hanson, 43 Van Natta 2578 (1991), aff'd mem 114 Or App 233 (1992).

Under this standard, and for the reasons stated by the majority, I find that claimant has established a compensable aggravation.

SAIF appears to argue that claimant has failed to establish that the worsening is more than the waxing and waning of symptoms contemplated by the previous permanent disability award, as required by ORS 656.273(8). The fault with that argument, as claimant points out, is 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).

A party ought to anticipate being held responsible for the logical consequences of any argument it presents to the forum on its own behalf. The argument that claimant did not experience a compensable aggravation because the loss of earning capacity was no more than anticipated waxing and waning could be interpreted as a concession that claimant sustained a "disabling compensable injury." ORS 656.005(7)(c). I note, however, that SAIF accepted the claim as one for a "nondisabling compensable injury," ORS 656.005(7)(d), and there is no evidence in the record that SAIF ever notified the Director of a disabling injury pursuant to ORS 656.262(12).

SAIF also contends that claimant has failed to establish that the worsening is causally related to his compensable injury, indicating that it is more probable that claimant's worsening was the result of an intervening injury. SAIF offers no evidence of an alternative cause. Rather, it notes claimant's volunteer firefighting activities and argues that, "[g]iven claimant's lack of credibility, claimant has failed to establish that the major contributing cause of the worsened condition is not an injury occurring outside the course and scope of his employment." (App. brief at 7).

SAIF's request that we find that claimant sustained an off-work injury simply because claimant is not credible is wholly improper and I decline to engage in such speculative fact finding. The request assumes that there is a presumption that a worsened condition is caused by an intervening event absent sufficient proof that it is not. Such a presumption is not found in the Workers' Compensation Law. Moreover, SAIF's request is not supported by the record. Nothing in the record casts doubt on claimant's credibility. To the contrary, his testimony is consistent and reliable. In addition, that testimony is consistent with, and is supported by, the record as a whole.

On May 14, 1991, Dr. Jackson reported that he had taken claimant off work from December 27, 1990 through March 7, 1991, and then again from May 7, 1991 through an indefinite period of time. In the report, which SAIF received on June 26, 1991, Dr. Jackson opined that claimant's April 1989 compensable injury was the major contributing cause of his worsened upper back condition.

On August 15, 1991, claimant was examined by a panel of physicians at the offices of the Orthopaedic Consultants. They did not believe that claimant's condition had worsened, but rather that claimant's symptoms were waxing and waning. (This conclusion is legally inappropriate as noted above.) However, they further noted that claimant's subsequent work and non-work activities did not contribute to his current condition.

On August 26, 1991, SAIF notified claimant that it was unable to open his claim for an aggravation on the basis that his condition had not worsened and, if it had, his compensable injury was not the major contributing cause of the worsening.

Accordingly, based on those opinions, and claimant's credible testimony, and in the absence of any evidence to the contrary, it was unreasonable to conclude that claimant had experienced an intervening injury and to base a denial, even in part, on that conclusion. In addition, a reliance upon that argument in the absence of any evidentiary support amounts to raising a frivolous issue on appeal. Because claimant was put to the effort of addressing that issue in his respondent's brief, I would increase the attorney fee awarded in keeping with the provisions of OAR 438-15-010(4).

In the Matter of the Compensation of
ROBERT E. HOWELL, Claimant
WCB Case No. 91-02462
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Hooton and Brazeau.

The insurer requests review of Referee Brown's order which: (1) increased claimant's scheduled permanent disability award from 7 percent (9.45 degrees) of the left foot (ankle) and 18 percent (24.30 degrees) of the right foot (ankle), as awarded by Determination Order, to 20 percent (27.0 degrees) of the left foot and 34 percent (45.9 degrees) of the right foot; and (2) ordered the award to be paid at the rate of $305 per degree. On review, the issues are extent and rate of scheduled permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

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

Because claimant's condition became medically stationary on May 14, 1990, and his claim was closed by Determination Order on January 23, 1991, 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. WCD Admin. Orders 6-1988, 15-1990 and 20-1990.

Because claimant became medically stationary before July 1, 1990, we rate disability as of the date of hearing. The amendments to ORS 656.283(7) and 656.295(5) do not apply. See Or Laws 1990, ch. 2, § 54(3); Stephen A. Roberts, 43 Van Natta 1815 (1991).

The Referee relied on the range of motion measurements of Dr. Maurer, claimant's treating orthopedic surgeon at the time of claim closure, which were made in Dr. Maurer's closing examination on May 15, 1990. (Ex. 23). The insurer argues that the Referee should have used the more recent range of motion measurements of Dr. Donahoo, the independent medical examiner, who examined claimant on August 22, 1990, and in whose report Dr. Maurer concurred in October 1990. (Exs. 21, 24).

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 worker's impairment for the purpose of evaluating the worker's disability." Thus, the statute as applied to the present case provides 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 worker's impairment. The attending physician may do so by concurring in and thereby adopting another physician's findings. See Dennis E. Conner, 43 Van Natta 2799 (1991).

Thus, as the attending physician at the time of claim closure, Dr. Maurer must make the findings regarding claimant's impairment. He did so in his May 15, 1990 closing examination. He also concurred in the later findings made by Dr. Donahoo. (Exs. 21, 24). For reasons to be stated below, however, we conclude that Dr. Maurer's concurrence did not intend for Dr. Donahoo's findings to supplant those of Dr. Maurer in his closing examination.

Turning to the impairment findings, we note that the Referee correctly analyzed claimant's scheduled disability pursuant to the May 15 closing examination by Dr. Maurer. In addition, Dr. Donahoo found that claimant's subtalar joint in each foot was ankylosed, or fixed. Although he observed "perhaps" some retained motion in the right subtalar joint, he concluded that it is "essentially a very stiff subtalar joint . . . and essentially has a fibrous ankylosis and a neutral position of the right subtalar joint." He found a similar situation in the left foot. (Ex. 21-4). He added, "I believe he should be rated as a functional arthrodesis of the subtalar joint in an optimum position." (Ex. 21-6). Accordingly, we conclude that, under the impairment findings provided by Dr. Donahoo, claimant would have been entitled to an impairment value for subtalar ankylosis at 0 degrees for each foot, rather than values for subtalar inversion and eversion ranges of motion. Former OAR 436-35-190(3), (5).

We evaluate claimant's impairment for both feet, pursuant to Dr. Donahoo's report, as follows:

	Retained ROM	Impairment
Ankle dorsiflexion	10 degrees	4%
Ankle plantar flexion	55 degrees	0%
Add highest ankylosis		10%
Total impairment		14%

Former OAR 436-35-190(3), (5), (6), (8), (11).

The insurer also argues that the evidence does not support the Referee's conclusion that claimant's ability to stand, walk or run is limited as a result of his bilateral heel fractures. We disagree. After our review of the record, we agree with the Referee's finding that claimant's ability to perform the aforementioned functions has been permanently limited. Accordingly, we adopt the Referee's conclusion that claimant is entitled to 15 percent disability of each foot under former OAR 436-35-200(4).

Therefore, if Dr. Donahoo's impairment findings had been used, the fracture finding of 15 percent would have been combined with the range of motion findings of 14 percent to yield a loss of 27 percent in each foot. Former OAR 436-35-190(11). Thus, the total scheduled permanent disability for both feet under Dr. Donahoo's findings would have been 54 percent.

Inasmuch as the total disability described by Dr. Maurer is also equivalent to 54 percent, we do not believe that Dr. Maurer intended that Dr. Donahoo's findings should supplant his own for purposes of rating disability. We, therefore, decline to modify either the award or the reasoning of the Referee on this issue.

Finally, the insurer contends that the scheduled permanent disability award should be paid at the rate of $145 per degree. We agree.

The Referee concluded that claimant's award of scheduled permanent disability should be paid at the rate of $305 per degree. The Referee relied on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), in which we held that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. Subsequent to the Referee's order, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992).

In this case, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury. ORS 656.202(2); Former ORS 656.214(2).

Because the insurer requested a reduction of claimant's permanent disability award as granted by the Referee, and we have declined to modify the award of scheduled disability, claimant's attorney is entitled to a reasonable attorney fee pursuant to ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying then to this case, we find that a reasonable assessed fee for claimant's counsel's services on Board review concerning the issue of scheduled permanent disability 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 issues and the value of the interest involved.

ORDER

The Referee's order dated June 20, 1991 is affirmed in part and reversed in part. That portion of the order which required the insurer to pay scheduled disability at the rate of $305 per degree is reversed. The remainder of the Referee's order is affirmed. For services on Board review, claimant's counsel is awarded a reasonable assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
PATRICIA A. LANDERS, Claimant
WCB Case Nos. 91-04554 & 91-04553
ORDER ON REVIEW
Flaxel, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

The insurer requests review of that portion of Referee Black's order that directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree. Claimant cross-requests review of that portion of the order that authorized an offset of overpaid temporary disability compensation, requesting that the offset be restricted to one of claimant's two accepted claims. On review, the issues are rate of scheduled permanent disability and offset. We reverse in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Rate of Scheduled Permanent Disability

The Referee concluded that claimant's award of scheduled permanent disability should be paid at the rate of $305 per degree. The Referee relied on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), in which we held that the amendment to ORS 656.214(2), which increased the

rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. Subsequent to the Referee's order, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992).

In this case, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury. ORS 656.202(2); former ORS 656.214(2).

Offset

Claimant contends that the offset allowed by the Referee against "this and any future award of permanent disability" should be granted against present and future permanent disability for the left leg claim (Claim No. E87025) only, because the overpaid temporary disability occurred on that claim.

Any determination or notice of closure may include necessary adjustments in compensation paid or payable prior to the determination or notice of closure. ORS 656.268(13) (Emphasis added). An offset of benefits paid on one claim against amounts due on another claim is not authorized. Steven M. Ginther, 42 Van Natta 526 (1990). Consequently, the offset allowed by the Referee against "this and any future award of permanent disability" is limited to an offset against present and future permanent disability in the left leg claim only.

ORDER

The Referee's order dated December 3, 1991 is reversed in part, modified in part, and affirmed in part. That portion of the order that directed the self-insured employer to pay the scheduled permanent disability award at the rate of $305 per degree is reversed. That portion of the order that allowed an offset of overpaid temporary disability compensation up to the amount of $4,873.43 is authorized against this and any future awards of permanent disability only in Claim No. E87025. The remainder of the order is affirmed.

In the Matter of the Compensation of
AGNES C. RUSINOVICH, Claimant
WCB Case No. 91-04808
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Menashe's order which increased claimant's unscheduled permanent disability award for a 1986 injury to her left shoulder and low back from 10 percent (32 degrees) awarded by Order on Reconsideration to 34 percent (108.8 degrees). Claimant cross-requests review seeking an assessed attorney fee. On review, the issues are extent of unscheduled disability and attorney fees. We affirm.

FINDINGS OF FACT

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

Claimant has an accepted back, left shoulder and psychological condition stemming from a 1986 compensable injury. Claimant's claim was closed by an October 8, 1990 Determination Order. At the time the Determination Order issued there was no closing report from claimant's attending physician and no such closing report had been requested. On November 13, 1990, claimant requested

reconsideration of the Determination Order on the basis that the Determination Order did not address all of the accepted conditions. In its Order on Reconsideration, the Appellate Unit declined to consider Dr. Nelson's November 5, 1990 report because the exam was performed post closure. The Order on Reconsideration also stated that there was no evidence that the back condition was an accepted condition.

CONCLUSIONS OF LAW AND OPINION

In reaching his conclusions regarding the extent of claimant's unscheduled permanent disability, the Referee relied on Dr. Nelson's November 5, 1990 evaluation. The Referee reasoned that this was the only report from claimant's attending physician and that pursuant to ORS 656.245(3)(b)(B) only the attending physician can make impairment findings.

In its brief, the insurer argues that the Referee improperly relied on Dr. Nelson's November 5, 1990 report, because this report was not in existence at the time of claim closure. The insurer further argues that the only report addressing impairment to claimant's shoulder is Dr. Button's report which finds no impairment. The insurer argues that absent Dr. Nelson's report, there are no findings of impairment of claimant's back and left shoulder. Therefore, the insurer reasons, claimant is not entitled to additional unscheduled permanent partial disability.

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). As a result, unless the attending physician concurs with such findings, 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); Raymond D. Lindley, 44 Van Natta 1217 (1992).

A number of things are evident from this record. First, Dr. Nelson did not make any findings regarding claimant's physical injuries prior to closure nor did he concur with or adopt any such findings made by the independent medical examiner (whose findings we are urged by the insurer to use). Second, although knowing that only Dr. Nelson, the attending physician, "may make findings regarding the worker's disability," the insurer did not request a closing examination and report from Dr. Nelson to enable the claim to be properly closed and claimant's disability rated consistent with law. Third, the Evaluation Section closed the claim and proceeded to evaluate claimant's disability without a closing report from the attending physician. Moreover, the Appellate Unit did not have accurate information regarding which conditions the insurer had accepted under the 1986 claim, and, therefore, failed to rate claimant's compensable physical disabilities.

ORS 656.268(5) provides 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."

Under the limited circumstances presented by this case, we hold that the report from Dr. Nelson, although produced upon examination after claim closure, constitutes for purposes of ORS 656.268(5), "medical evidence that should have been but was not submitted by the physician serving as the attending physician at the time of claim closure." Accordingly, it was properly received in evidence at the hearing and used by the Referee for the purpose of evaluating claimant's disability. Any other interpretation of the statutes involved, especially that interpretation urged by the insurer, would not only circumvent the purposes and policies of the Workers' Compensation Law as amended by the 1990 Special Session of the legislature, it would indeed do a manifest injustice to claimant.

Claimant has cross-appealed requesting an attorney fee pursuant to former ORS 656.382(4) because claimant's permanent disability award was increased by more than 25 percent and she was more than 20 percent permanently disabled. However, the portion of ORS 656.382(4) cited by claimant

applied only to claims closed by the insurer or self-insured employer. Furthermore, subsection (4) was repealed by SB 1197. ORS 656.268(4)(g) allows such a penalty against the insurer if on reconsideration the department orders an increase by 25 percent or more of the amount of permanent disability and the worker is at least 20 percent disabled. However, this statute also only applies to claims closed by the insurer or self-insured employer and the penalty is paid to claimant, not claimant's attorney. Here, the claim was closed by Determination Order. Therefore, no penalty may be assessed pursuant to this statute.

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 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 claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated July 25, 1991 is affirmed. For services on review concerning the extent of unscheduled permanent disability issue, claimant's attorney is awarded $2,000 payable by the insurer.

In the Matter of the Compensation of
REXI L. NICHOLSON, Claimant
WCB Case No. 91-03460
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Gary T. Wallmark (Saif), Defense Attorney

Reviewed by Board en banc.

Claimant requests review of that portion of Referee T. Lavere Johnson's order that dismissed her hearing request for lack of subject matter jurisdiction. On review, the issue is jurisdiction. 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 found that, pursuant to ORS 656.704(3) and 656.245(1)(b), the Hearings Division did not have subject matter jurisdiction over the recommended palliative care at issue. He also found that the correct procedural route for review of the Palliative Care Order was to the Director of the Department of Insurance and Finance, not to the Hearings Division. We agree.

Here, claimant qualifies for none of the exceptions to the general rule that post-medically stationary palliative care is not compensable. Claimant had been receiving palliative chiropractic treatments from Dr. Renquist since her claim was first closed by Determination Order on November 4, 1986. On July 23, 1990, Dr. Stringham, claimant's attending physician, requested that the palliative chiropractic treatments continue on a twice monthly basis. (Ex. 10). The SAIF Corporation denied this request. (Ex. 11). Dr. Stringham requested approval from the Director. After a physician's review, the Medical Advisor, acting on behalf of the Director, issued an order in which he found, in part, that the requested palliative care was not necessary to enable claimant to continue current employment. (Ex. 17,

18). The Director's order provided appeal rights allowing a request for administrative review by either the insurer or the attending physician pursuant to OAR 436-10-008(6). The attending physician did not request administrative review. Instead, claimant requested a hearing.

This case presents two questions regarding the issue of jurisdiction. First, does the Board, and thus its Hearings Division, have original jurisdiction over otherwise noncompensable palliative care disputes? Second, does the Board, and thus its Hearings Division, have jurisdiction to review the Director's Palliative Care Order?

We have previously answered the first question in the negative. Pursuant to ORS 656.283(1), any party may request a hearing on any matter concerning a claim. However, pursuant to 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 2463 (1991). We have held that ORS 656.245, as amended, provides a procedure for the resolution of disputes involving palliative care. Robert D. Cox, 43 Van Natta 2726 (1991); Joan E. Hathaway, 43 Van Natta 2730 (1991). Thus, the Hearings Division does not have original jurisdiction to consider claimant's request for palliative chiropractic care.

As to the second question, we also answer it in the negative. ORS 656.245(1)(b) provides that, after a worker becomes medically stationary, palliative care is not compensable except under certain circumstances not applicable in this case. ORS 656.245(1)(b) also provides:

> "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. The director shall appoint a panel of physicians pursuant to ORS 656.327(3) to review the treatment."

ORS 656.327 provides the procedures for Director review of contentions that medical treatment an injured worker is receiving is "excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services." ORS 656.327(1)(a). Specifically, ORS 656.327(3) authorizes the Director to delegate to a panel of physicians the review of the requested medical treatment. ORS 656.327(3) also provides that the "panel shall submit findings to the director in the same manner and within the time limits as prescribed in subsection (2) of this section." ORS 656.327(2) provides for both: (1) the manner and time limits to be followed by the Director in his review of the medical information; and (2) review of the Director's order by the Hearings Division as provided in ORS 656.283, if review is requested by the dissatisfied party.

In determining whether this Board has jurisdiction to review an order by the Director regarding otherwise noncompensable palliative care, we find it significant that ORS 656.245(1)(b) refers specifically and only to ORS 656.327(3) concerning the makeup of the panel of physicians. ORS 656.245(1)(b) makes no reference to ORS 656.327(2), which provides for review of a Director's order by the Hearings Division. Furthermore, the reference in ORS 656.327(3) to ORS 656.327(2) pertains only to the process by which the medical panel is to submit its findings to the Director. ORS 656.327(3) does not authorize the Board to review the medical panel's findings or refer to the process that ORS 656.327(2) provides for Board review of a Director's order in "medical services disputes" arising under subsection (1) of that provision. Given this statutory trail, we find that the legislature did not empower this Board and its Hearings Division to review a Director's order approving or disapproving an attending physician's request for otherwise noncompensable palliative care. Indeed, we find that the legislature has purposefully treated palliative care differently than other medical services both procedurally and substantively.

Although there is not a wealth of legislative history on medical services in general and on palliative care in particular, the legislative history on those subjects supports the conclusion we have reached. As for medical services in general, the legislature's primary policy objective was to remove from the litigation process questions about the reasonableness and necessity of medical treatment, by

having such questions decided by physicians rather than by Referees. See Minutes, Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 3, side A at 75. Thus, by virtue of the 1990 amendments, such questions are no longer "matters concerning a claim" over which this Board's Hearings Division has original jurisdiction. Stanley Meyers, supra.

As for palliative care, the legislature went even further. Before the 1990 amendments, the Workers' Compensation Act did not differentiate between curative medical services and purely palliative care. ORS 656.245(1) provided for full medical services "for conditions resulting from the injury for such period as the nature of the injury or process of recovery requires." Such services included those rendered for purely palliative purposes. West v. Montgomery Ward, Inc., 10 Or App 333 (1972). That is no longer the case. ORS 656.245(1)(b), as amended, now provides that "palliative care is not compensable" with certain limited exceptions that are not applicable here. At the beginning of the 1990 Special Session, the Labor-Management Advisory Committee initially proposed restrictions which would have made palliative care substantially unavailable without exception. See Statement of Senator Cohen, Senate Special Session, May 7, 1990. However, the limited exceptions not applicable here were ultimately adopted in amended ORS 656.245(1)(b). More important to the question, the legislature established a special process for resolving disputes about palliative treatment that would "otherwise not be compensable." If approval is not granted by the insurer, "the attending physician may request approval from the director," and upon such request, the "director shall appoint a panel of physicians" to review the treatment. ORS 656.245(1)(b).

The Director has promulgated rules to carry out the medical panel review process established by amended ORS 656.245(1)(b). OAR 436-10-041(11) provides for review of a Director's order regarding an attending physician's request for approval of palliative care pursuant to OAR 436-10-008(6). OAR 436-10-008(6) provides that "the insurer or attending physician aggrieved by an order approving or disapproving palliative care to enable an injured worker to continue current employment may request review by the director." This review process includes an administrative review by right and a discretionary contested case hearing before the Director. OAR 436-10-008(6)(a) through (e).

Based on the statutory language and the absence of any contrary expression of legislative purpose in the legislative history, we conclude that the Board and its Hearings Division has no jurisdiction to review a Director's order regarding an attending physician's request for palliative care. Instead, the Director has exclusive jurisdiction over such questions. Thus, we agree with the Referee that the Hearings Division is without jurisdiction in this matter.

In reaching this conclusion, we recognize that dissenting members Kinsley and Hooton agree that, under current Board precedent, amended ORS 656.245 gives the Director exclusive jurisdiction over this dispute concerning palliative care. They argue, nonetheless, that the Board must continue to assert jurisdiction because the procedure provided by ORS 656.245(1)(a) infringes the right of injured workers to procedural due process under the Oregon and federal constitutions.

In response to the dissent, we have only two points. First, no party has questioned the validity of ORS 656.245(1)(a) on constitutional grounds, and we believe it would be inappropriate for this Board to journey into the thorny thicket of the dissent's constitutional analysis when the issue has not been raised. Second, assuming, as the dissent contends, that the new procedure is unconstitutional (because the injured worker's physician, but not the injured worker, may request Director review), it would not be necessary or appropriate for the Board to declare the statute invalid and assert jurisdiction. Rather, our first duty would be to interpret the statute in such a way as to avoid the unconstitutionality without obstructing the legislature's central purpose. This could be done by construing the statute to allow the injured worker to request Director review subject to the requirement that the request be supported by an explanatory report from the worker's treating physician. Since there is a less drastic alternative available which would be consistent with the legislature's intent, the appropriate action for the Board would not be to declare the statute invalid in toto and assert jurisdiction as though the statute did not exist. In any event, the constitutional question addressed by the dissent was not raised in this case.

ORDER

The Referee's order dated August 20, 1991 is affirmed.

Board Member Gunn specially concurring in part and dissenting in part.

I agree with the majority that this case involves two questions. On the first question, I agree with the majority that review of the palliative care question is not a matter concerning a claim, and is outside the Board's jurisdiction and falls under the provisions of ORS 656.327.

I disagree with the majority's conclusion that the Board does not have a right of review of a Director's order arising from ORS 656.327(3). I dissent not based on the excellent legal arguments put forth by Members Kinsley and Hooton, but based solely upon my reading of ORS 656.327. I would also hold that the legislative changes support a conclusion that the legislature intended to expand Board review.

First, I find no reason to blaze a statutory trail between ORS 656.245 and 656.327. I also believe the majority begins its legislative trail burdened with a knapsack of incorrect legislative assumptions. The majority, grappling with a legislative history which intended to restrict palliative care, applies such history as also imposing restrictions on review rights to palliative care disputes under ORS 656.327(3). However, I find that there is no legislative history to support this distinctive restriction to Director review under ORS 656.327. In fact, the legislature's actions in ORS 656.327 lead to the conclusion that it meant to expand Board review of the Director's actions under ORS 656.327.

It is evident from reading the additions and deletions in ORS 656.327 that the provision was intended to expand the Director's authority to review medical treatment issues. The first question under ORS 656.327 is whether a "bona fide medical dispute" ever existed. It should be noted that the new section in .327(b) is directly applicable to the Board, under the same standards in ORS 656.283. The legislature actually expanded Board review powers in its modification of ORS 656.327. To conclude that the legislature intended to reduce Board review is not supported by the legislative record or the actual language modifications that the legislature placed in ORS 656.327.

Lastly, the majority's conclusion is not supported by the actual language of ORS 656.327. The majority concludes that review under ORS 656.327(2) is the only process subject to Board review under ORS 656.283. However, the majority ignores that ORS 656.327(3) is only an alternative form of Director review leading to an order issued by the Director "upon request of either party." See ORS 656.327(3). It is apparent from this language that parties may request Director review of medical treatment questions by use of a panel. The panel is responsible to issue findings "in the same manner and within the time limits as prescribed in subsection (2) of this section." See ORS 656.327(3). These findings form the basis for a Director's order. The majority would conclude that if claimant or the insurer requested review of medical treatment by a panel as allowed under ORS 656.327(3) that they would waive review rights under ORS 656.327(2). ORS 656.327 is a statute that sets out how the Director reviews and then issues order on medical treatment questions. To say that orders issued under ORS 656.327(3) lack the same review rights as every order issued under this section is illogical and inconsistent.

In SAIF v. Herron, 114 Or App 64 (1992), the court noted that "neither we nor the Board is at liberty to rewrite legislative history, our task is to determine what the legislature intended by its use of certain words." In sum, the job of the legislature is to enact words, thus, the words chosen cannot be ignored. I would further add that the words must be read in context of the whole and guided by the following legislative presumptions.

In determining the intention of the legislature, we ought to be aided by the obvious. In particular, that the legislature did not intend a result that is absurd, impossible of execution, or unreasonable. The legislature did not intend to violate the Constitution of the United States or of this state, and that the legislature intended to favor the public interest as against any private interest. Also see Davies, Jack, Legislative Law & Purpose 297 (2d ed. 1986).

Granted, it would be inconceivable to divert from an approach which adhered merely to the words enacted if everyone read words as having identical meanings, if drafters toiled flawlessly, if legislators knew precisely what they proposed to convey, and if humans could envision all possible instances that could arise under any legislative enactment. But the folly of being human is to at times fail at each of these tasks. Although, the legislature and its legislative committees may, more often than not, rise to the occasion, it is a reality, that at other times, the circumstances are more aptly described by

the following quote by Prussian chancellor Bismarck: "No man who loves laws or sausages should see how either are made."

Therefore, we ought to follow a statutory trail only until it leads "to any absurdity or manifest injustice." Id at 295. Accordingly, absent clear legislative history or intent, or better yet, specific exclusionary language, I would find no reason not to allow Board review of a Director's order issued under ORS 656.327(3).

Based upon the foregoing finding, I now turn to review of the Director's order. (Ex. 21).

The Director did not appoint a panel to review claimant's treating physician's request. However, clearly in the legislative record are reasons for requiring the Director to appoint a panel:

> "Rep. Shiprack: Mr. Chairman, just very briefly to help clarify. I wasn't aware of a paranoia problem in this section, but in the section we're talking about, let's get back to reality. In section 10 the worker is at work. The palliative treatment is necessary for that person to continue working. The point that hasn't been brought up is that the insurer pays for this panel of physicians. We want them to be paid well because in order to have this panel and have these doctors serve on the panel, they're not going to be cut-rate. They'll be their reasonable and customary fees which are about $500 now per examinations. You've got three of them. An insurance company that wishes to deny this type of treatment is going to have to pay $1500 for this medical panel versus perhaps a $60 treatment once a month. If they feel that's cost effective then I think our labor management committee may want to take a look at them. That's the call here. The other option, of course, is if the treatment is denied, that person will most likely go off of work. We've got a new claim, time loss benefits and perhaps thousands of dollars that the insurer is looking at versus the $60 treatment. So sometimes we have to look at what really happens in the real world and that's a significant choice that insurers are going to have to make.
>
> "Mr. Dwinell: As I understand the process to handle this situation, if the attending physician felt that that type of maintenance was necessary to keep the person working, then first you will submit to the insurer and ask them to pay the bill and it may end right there. However, if the insurer refuses to pay the bills then it would go into this appeal where you would write to the Medical Director and a medical arbiter or panel of physicians would make the decision on it.
>
> "Mr. Tibbetts: A key factor in that is that the panel that would make the decision on palliative car has to include a member of the class of treating physicians. So in the example you give, the panel reviewing that palliative care request would have to include a chiropractor." (Joint Committee Hearings, Tape 2, Side A).

Moreover, the express language in ORS 656.245(1)(b) provides, in pertinent part:

> " * * * The director shall appoint a panel of physicians pursuant to ORS 656.327(3) to review the treatment." (Emphasis supplied).

I note that "shall" is the most powerful word in a legislature's arsenal. It is a word of command and the proper use of "shall" is to give an order. If the legislature's intent was to give permission, the word "may" would have been used. Therefore, inasmuch as the statute utilizes a muscular shall, I would find that the Director's failure to appoint a panel, renders the order invalid as a matter of law. Accordingly, I would remand to the Director to appoint a panel as required by ORS 656.245(1)(b) and 656.237(3).

Board Members Hooton and Kinsley dissenting.

The majority opinion identifies two issues in this case. First, does the Board, and thus its Hearings Division, have original jurisdiction over otherwise noncompensable palliative care disputes? Second, does the Board, and thus its Hearings Division, have jurisdiction to review the Director's

Palliative Care Order? The majority concludes that the appropriate response to both issues is the negative. We conclude that the Board and, therefore, the Hearings Division, has original jurisdiction over claimant's request for hearing regarding palliative medical treatment because the procedure authorized by statute is unconstitutional and, therefore, invalid. Because we disagree with the majority as to the first identified issue, we do not need to address the second, except to state that, since we would find that the Board has original jurisdiction, the appropriate procedure for review is necessarily under ORS 656.295.

However, the manner in which the second issue is raised before the Hearings Division and before the Board on review creates significant concerns which require some preliminary comment. It is the parties, by their request for hearing and response, that establish the issues to be resolved by the referee at hearing and, by request or cross-request for board review, the issues to be resolved by the Board. Claimant raises only the original jurisdiction of the hearings division and the Board to hear questions related to claimant's need for palliative medical services.[1] No cross request either for hearing or Board review has been filed.

The question reached by the majority, and the basis for most of the majority opinion, was raised at hearing by a representative of the Department of Insurance and Finance appearing on behalf of Dr. William Craig, Medical Director. That representative, D. Kevin Carlson, Assistant Attorney General, was present only for the purpose of argument involving a subpoena served on Dr. Craig which the Department sought to quash. The argument presented by Mr. Carlson in favor of the Department's original jurisdiction was wholly irrelevant to the question whether the subpoena served on Dr. Craig should be quashed. Certainly, however, even if relevant to that the subpoena issue, it should not be given any effect or consideration in the remaining dispute between the parties.

Further, it was error for the Board to permit the Department to file a brief and argue in support of jurisdiction before the Board as though the Department were a party to all the issues in the proceeding below. Since DIF was not a party to the hearing, is not a party on review, did not request a hearing or request or cross-request review, did not seek to intervene and did not request the consent of the Board to file an amicus brief, its submission of argument on any matter, other than the evidentiary matter on which it appeared and from which no exceptions were taken and no review has been requested, is wholly inappropriate.

The only issue raised by either party at hearing and on review is the original jurisdiction of the Board and the Hearings Division to determine claimant's entitlement to palliative care. Under the express terms of ORS 656.704(3), matters concerning a claim do not include questions of medical treatment or fees for which a procedure is otherwise provided in Chapter 656 of the Oregon Revised Statutes. We conclude that a procedure is not otherwise provided if (1) no procedure is specifically outlined in the statute; (2) the procedure outlined by the statute is constitutionally invalid; or (3) the procedure as actually applied is constitutionally invalid and therefore not available in the manner provided by the statute.[2]

NO PROCEDURE IS PROVIDED IN CHAPTER 656

Chapter 656 of the Oregon Revised Statutes does not provide a procedure for the resolution of

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[1] We note that the insurer apparently adopted the argument of the Department at hearing but abandoned it on appeal. In its brief the insurer argues that a denial of palliative care is a denial of the appropriateness of treatment under ORS 656.327. This would produce an identical proceeding before the Director but the rights to review established under ORS 656.327 would control, including the right to review under ORS 656.283.

[2] Because the parties have not raised this issue, and because it is not a question raised by the statute itself, we decline to reach this question at this time. In addition, the evidentiary ruling quashing the subpoena of Dr. Craig prevented the parties from presenting evidence on the question whether a panel examination is a requirement of statute that could be overcome by a legitimate state interest. We note that the panel requirement appears to be an attempt to provide an impartial decisionmaker, an essential due process requirement. Consequently, we agree with Board member Gunn's assertion that the Director's Order is invalid for failure to follow the procedure required by ORS 656.327(3), even if it is not otherwise invalid for the reasons stated in this dissenting opinion.

disputes regarding palliative care. To provide a procedure sufficient to meet the terms of ORS 656.704, the procedure must be available to the party seeking relief. While we acknowledge that ORS 656.245(1)(b) does outline a permissive procedure for the resolution of such disputes, that procedure excludes claimants as potential parties by its express terms. Therefore, claimant has no procedure available and we retain original jurisdiction over a request for hearing on a palliative care issue.

We have previously defended a construction of ORS 656.704(3), and those statutes to which it might apply, which would limit its effect on a party's right to seek the dispute resolution forum traditionally available. See, Tracy Johnson, 43 Van Natta 2546, 2547 (1991); Stanley Meyer, 43 Van Natta 2643, 2649 (1991); and Gladys M. Theodore, 44 Van Natta 905, 908 (1992). Those arguments remain applicable in the present dispute.

ORS 656.012 sets out the purposes and objectives of the Worker's Compensation Law. By its terms it identifies the Law as remedial. Consequently the Law, in its entirety, is to be construed in the manner most favorable to injured workers. Liberty Northwest Insurance Corp. v. Short, 102 Or App 495 (1990). ORS 656.704(3), and the sections to which it applies, can only be interpreted in the light most favorable to the injured worker if the terms are strictly construed to require a procedure laid out in express terms by the legislature in Chapter 656. Where a procedure is subsequently developed by the department under its general regulatory authority from general statutory terms, that procedure is not a procedure provided by Chapter 656. Finally, a procedure is not provided by Chapter 656 if it is not expressly available to the party aggrieved.

We agree with the majority that a procedure is specifically provided by ORS 656.245(1)(b), outlined with sufficient particularity to meet the requirements of ORS 656.704(3). However, because that statute limits the availability of the procedure to insurers and attending physicians, claimant's access is prohibited. Therefore, claimant has no procedure within Chapter 656 for the resolution of this dispute, and the Hearings Division retains jurisdiction.

ORS 656.245(1)(b) IS CONSTITUTIONALLY INVALID

The Fifth and Fourteenth Amendments to the United States Constitution prohibit state action which deprives individual citizens or groups of citizens of life, liberty or property without due process of law. The "due course of law" provision of the Oregon Constitution at Article I, section 10 has been construed by the courts as essentially the same as the "due process of law" provision of the Fourteenth Amendment. Carr v. SAIF Corporation, 65 Or App 110, 115 (1983); Tupper v. Fairview Hospital, 276 Or 657, 664 n 2, (1977).

Before reaching the merits of the question of constitutionality, however, it is necessary to consider two preliminary concerns. First, does this body have the authority to determine whether ORS 656.245(1)(b) is constitutionally invalid? Second, if we have that authority, should we reach the question in this instance?

The Oregon Supreme Court has determined that Oregon administrative agencies have the power to declare statutes and rules unconstitutional. It cautioned, however, that it is an authority that is to be exercised infrequently. Nutbrown v. Munn, 311 Or 328, 346 (1991). We take this to indicate that administrative agencies ought to exercise the same restraint that the Court would exercise in reaching a constitutional issue. In the present circumstances, we find it unavoidable.

Workers' compensation is a creature of statute. No party in a workers' compensation proceeding has a right not expressly granted by statute. Administrative agencies lack the power to enlarge upon or diminish the rights awarded by the plain language of the statute. See Kemp v. Workers' Comp. Dept., 65 Or App 659, 667-670 (1983). ORS 656.245(1)(b) creates a procedure for the resolution of palliative care disputes at which only the insurer and the attending physician are parties. Neither the Department nor this Board has the authority to construe the plain language of the statute to grant claimant access to the procedure. If the failure to provide access to claimant violates her due process rights under federal and state constitutions, the procedure itself is constitutionally invalid, and therefore a nullity. If the procedure is a nullity, there is no procedure under ORS 656 that would limit claimant's right to a hearing under ORS 656.704(3). Because the constitutional issue is central to our determination on jurisdiction, it cannot be avoided.

Because jurisdictional issues may be raised at any time in the proceeding, and may be raised sua sponte, we need not, and should not await a full argument on the issue by the parties. Even if it is arguable that we should not reach this issue unless it is raised by the parties, we find that the parties have done so, however inexactly. At the time of hearing and on Board review, claimant argued that the imposition of the Director's Order without allowing claimant a hearing, deprives her of the opportunity to present evidence and participate in the adjudication of an essential right. (Transcript @ 41, App. Brief @ 6). No matter how inexactly stated, that argument represents an assertion that claimant is denied due process of law. We conclude that the issue is properly before us, either on our own motion or as raised by the parties, and proceed to address it.

Before determining whether the procedure outlined in ORS 656.245(1)(b) represents a denial of due process, it is necessary to determine whether claimant's interest in receiving palliative care is an interest to which due process protection will attach. We conclude that it is.

States may not deprive citizens of life, liberty or property without due process of law. In keeping with the changing nature of modern society, the United States Supreme Court has construed the term "property" to include not only tangible property interests, but also interests created by statute in the way of entitlement to certain benefits. Mathews v. Eldridge, 424 US 319, 96 S Ct 893, 47 L Ed 2d 18 (1976); Goldberg v. Kelly, 397 US 254, 90 S Ct 1011, 25 L Ed 2d 287 (1970). The Oregon Court of Appeals has recognized this distinction and applied it to temporary disability benefits under the Workers' Compensation Law. Carr v. SAIF, supra. The basic requirement to determine whether a due process right is created is to determine whether "the recipients' claims of entitlement to the benefits are grounded in the statutes defining eligibility for them". Carr v. SAIF, 65 Or App @ 117.

ORS 656.245(1) provides an entitlement "for every compensable injury" to all medical care that "the nature of the injury or the process of recovery requires." This phrase has been construed to create an entitlement to all "reasonable and necessary" medical care or treatment. Wait v. Montgomery Ward, Inc., 10 Or App 333, 335 (1972). See also Williams v. Gates McDonald and Company, 300 Or 278 (1985). ORS 656.245(1)(b), enacted by the 1990 Special Legislative Session, limits claimant's entitlement to palliative medical care. Consequently, claimant is no longer entitled to all medical care that the nature of the injury or the process of recovery requires. However, claimant remains entitled to such palliative care as the statute does allow. This includes all palliative care if claimant is permanently and totally disabled, all palliative care necessary to monitor prescription medication or prosthetic devices and all palliative care reasonably required to maintain current employment. In this case, claimant argues that palliative care is required to maintain current employment. Consequently, claimant seeks to establish that she is specifically entitled to palliative care by the terms of the statute. Because that issue involves an entitlement to benefits grounded in the statute defining eligibility, claimant is entitled to due process as a matter of law. Carr v. SAIF, supra.

Having determined that claimant is entitled to the protections of due process, the next step is to determine what process is due. It is not the case that a full evidentiary hearing is always required. To determine the minimum characteristics of a particular proceeding that are necessary to meet the requirements of due process, it is necessary to examine the three factors identified in Mathews v. Eldridge, supra.

First, we consider the nature of the interest affected. In this case that interest is medical care necessary to maintain current employment. By definition this is a significant interest affecting the claimant. If claimant is entitled to, but does not receive, the necessary care, she will not be able to continue in an endeavor which currently provides for her subsistence, and other necessities of life.

Second, we consider the risk that the procedure used will render an erroneous determination. Pursuant to ORS 656.266, the claimant bears the burden of establishing the compensability of her medical services claim. Because the procedure outlined in ORS 656.245(1)(b) requires claimant's attending physician to go forward with claimant's burden of proving the necessity of treatment to the continuation of employment, the risk of an erroneous determination is great. Claimant's attending physician does not have interests identical to those of the claimant. If the attending physician fails to vigorously defend claimant's right, it is the claimant, and not the physician, who is unable to receive medical treatment necessary to continue employment. The procedure in ORS 656.245(1)(b) requires that the physician take time which would otherwise be devoted to the medical care and treatment of other

patients from whom he is more likely to receive timely remuneration for his services. An attending physician has an economic disincentive to undertaking the defense of claimant's rights.

The problems created by relying on the attending physician are apparent in this case. While the physician requested the Director's review he did not follow through and provide the necessary documentation for a full and complete determination. The physician reviewer's report indicates that the treating physician failed to provide even a diagnosis of claimant's condition. Consequently, the Order of the Director is not based upon a fully developed record and the order cites a general failure of proof as the basis for the Director's decision.

Finally, we address the nature and extent of the State of Oregon's interest in the procedure provided. In this case, that interest involves administrative efficiency and expediency in the resolution of cases without costly and time consuming litigation. Those interests have previously been evaluated and determined to be insufficient to overcome claimant's right to notice and an opportunity to present evidence. See, for example, Carr v. SAIF, supra.

Given this analysis, The only reasonable conclusion is that nothing short of a full evidentiary hearing is sufficient to protect claimant's entitlement to palliative care necessary to maintain current employment.[3] Nevertheless, while acknowledging that every entitlement giving rise to a due process right will not require a full evidentiary hearing to withstand constitutional scrutiny, the courts have universally held that there are three elements necessary to meet the minimum due process requirements of any proceeding. Those elements are notice, a meaningful opportunity to be heard and an impartial decision maker. Carr v. SAIF, supra. See also, Goldberg v. Kelly, supra.

Because claimant is not entitled to notice or an opportunity to meaningfully participate in the proceeding, but must rely instead upon the benevolence of the attending physician to fully develop the record, the proceeding established in ORS 656.245(1)(b) is not sufficient to withstand constitutional scrutiny and is, therefore, invalid.[4]

Because no constitutionally valid procedure is provided for the resolution of palliative care issues in Chapter 656, the Board retains jurisdiction to resolve the matter pursuant to ORS 656.704(3) and we would remand the claim to the Referee for a full evidentiary hearing consistent with ORS 656.283.[5]

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[3] The majority concludes that the constitutional questions raised here are easily addressed by finding that claimant has the right, under ORS 656.245(1)(b) to request review by the Director. Because we conclude that claimant must be entitled to a full evidentiary hearing, we do not find the majority position adequate to meet the concerns raised. The Director, by rule without apparent statutory authority, allows only a discretionary contested case hearing, not a hearing as a matter of right, and that hearing specifically excludes the claimant. OAR 436-10-008(6).

[4] We note that, even if ORS 656.245(1)(b) is read to permit review under ORS 656.283, pursuant to ORS 656.327(2) that would not be enough to establish a proceeding consistent with the requirements of due process because it is a review proceeding under a substantial evidence test of a decision made in a proceeding in which claimant had no meaningful opportunity to participate.

[5] Finally, we note, but do not decide, that ORS 656.245(1)(b) may also be unconstitutional on other grounds. Article I, section 20 of the Oregon Constitution prohibits laws granting privileges or immunities to any citizen for class of citizens which are not available to all citizens upon the same terms. Of the two parties in interest to a palliative care dispute only the insurer is granted access to a forum in which that dispute can be resolved. In State ex rel Borisoff v. Workers' Compensation Board, 104 Or App 603 (1990), the court stated that "[a] class defined only by the law in question is simply a natural result of lawmaking, for 'every law itself can be said to "classify" what it covers from what it excludes" 104 Or App @ 608 (Citations omitted). The court has recently furthered this analysis by stating that "a privileges and immunities challenge will not succeed if 'the law leaves it open to anyone to bring himself or herself within the favored class on equal terms.'" Peacock v. Veneer Services, 113 Or App 732 (1992). The distinction between insurer and claimant, however, is a matter of contract and evident in present society in all first party insurance matters, and therefore not a classification that derives from the language of the statute in question. It is also impossible for claimants to bring themselves within the favored class.

In the Matter of the Compensation of
TERRANCE N. CHASE, Claimant
WCB Case No. 90-13726
ORDER ON REVIEW
Karen Werner, Claimant Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of that portion of Referee Emerson's order which declined to authorize an offset of allegedly overpaid temporary disability. On review, the issue is offset. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant filed a claim for a neck and back condition in 1987. This claim was accepted as a nondisabling injury. In December 1989, claimant was treated for a noncompensable brain aneurysm. While claimant was off work due to the aneurysm and surgery to correct the aneurysm, the insurer paid $2,917.43 in temporary total disability. No claim for workers' compensation benefits was filed by claimant with regard to the brain aneurysm condition. The 1987 claim was closed by Determination Order on May 5, 1990. The Determination Order awarded no temporary or permanent disability. As a result of the hearing in this matter, the Referee awarded claimant 5 percent (16 degrees) for claimant's 1987 low back injury. The Referee declined to authorize an offset of the $2,917.43 paid as temporary disability against the permanent disability award. The Referee reasoned that the insurer's mistaken payment was in the nature of "interim" compensation and could not be recovered. We disagree.

The insurer had an open claim for which claimant was receiving medical treatment at the time the noncompensable brain aneurysm was discovered. Claimant concedes that he made no claim for, or with respect to, the brain aneurysm. (Tr. 4). It necessarily follows that the payments were not "interim compensation" on a brain aneurysm claim. Under the circumstances, the insurer had no basis other than the 1987 claim, which was in open status at the time, to make any payments of temporary total disability compensation. Thus, the payments made constituted an overpayment for which the insurer is entitled to an offset.

The insurer is authorized to offset the $2,917.43 paid in temporary disability against this award and any future awards of permanent disability made in this claim.

ORDER

The Referee's order dated September 10, 1991, as reconsidered September 27, 1991 is reversed. The insurer is authorized to offset $2,917.43 against the Referee's award of permanent disability, as well as any future permanent disability awards in this claim. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
SHARRON R. CLARK, Claimant
WCB Case No. 90-20198
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Foss, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The insurer requests review of that portion of Referee Spangler's order that set aside its denial of claimant's left thumb arterial venous hemangioma condition. Claimant cross-requests review of the Referee's ruling not to admit a report offered by claimant immediately prior to closing arguments. On review, the issues are compensability and evidence.

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

On June 13, 1991, a hearing was convened. Before testimony was heard, the insurer's attorney requested that the hearing be continued in order to depose Drs. Wilson and DuPriest. There was no objection to the request by claimant's counsel, and the Referee granted the motion. (Tr. 8-9). The record also was held open for closing arguments. (Id. at 53). The Referee also admitted into evidence the deposition of claimant's treating physician, Dr. Whitney, with the transcript to be provided to the Referee when it became available. (Id. at 16).

On June 26, 1991, the insurer elected not to depose Drs. Wilson and DuPriest. Closing arguments were scheduled for August 9, 1991. On that date, immediately prior to closing arguments being heard, claimant's attorney offered into evidence a medical report, asserting that it had not been received in his office until August 7 and that he had been out of the office until August 9, when he discovered the report. The insurer's attorney opposed the motion.

The Referee ruled against claimant on the basis that: the original February 1991 hearing date had been continued at claimant's request for further evidence gathering; there was no motion by claimant during the hearing to leave the record open for receipt of further evidence; and the second ruling to continue was limited to receive the depositions of Drs. Wilson and DuPriest, as well as hear closing arguments. The medical report therefore was received only as an offer of proof.

In his cross-request for review, claimant challenges the Referee's ruling not to allow the medical report into evidence. Claimant asserts that the report should have been admitted because claimant's attorney "exercised due diligence and this report did not go beyond the scope of the already existing record."

In those circumstances where a Referee has continued the hearing for particular purposes and a motion subsequently is made offering evidence that does not fit into those purposes, we have found that the Referee had discretion not to allow such evidence into the record. See T.S. Nacoste, 42 Van Natta 1855, 1856 (1990); Hayward A. Clark, 41 Van Natta 1674, 1675 (1989). Here, the offered report clearly went beyond the Referee's ruling to continue the hearing to receive the depositions of Drs. Wilson and DuPriest and to hear closing arguments. We, therefore, conclude that the Referee had discretion not to allow the report into evidence.

Claimant's attorney is entitled to an assessed 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 is $1,200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated September 6, 1991 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,200, to be paid by the insurer.

In the Matter of the Compensation of
JAMES W. CROOKER, Claimant
WCB Case No. 90-19649
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

The self-insured employer requests review of that portion of Referee Livesley's order which partially set aside its denial of claimant's injury claim for a left knee meniscal tear. Alternatively, it seeks review of the Referee's $3,400 assessed attorney fee award. The issues on review are compensability and attorney fees. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

Citing ORS 656.005(7)(a)(B), the Referee concluded that claimant had established that he sustained a compensable injury on January 18, 1990 and that the injury, rather than his preexisting degenerative joint disease, was the major contributing cause of his left knee meniscal tear condition and need for medical treatment. While we agree with the Referee's conclusion, we substitute the following analysis.

We apply a two-part analysis in cases involving preexisting conditions. Bahman M. Nazari, 43 Van Natta 2368 (1991). First, claimant must establish that he suffered an accidental injury arising out of and in the course of employment, and that the injury was a material contributing cause of his disability and/or need for treatment. See ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). The disability and/or need for medical treatment must be established by medical evidence supported by objective findings. See Suzanne Robertson, 43 Van Natta 1505 (1991). Then, if there is a preexisting condition and that condition combined with the injury to cause or prolong disability or the need for treatment, claimant is entitled to compensation if the injury was the major contributing cause of the resultant disability or need for medical treatment. ORS 656.005(7)(a)(B).

On this record, we first conclude that claimant has established a compensable injury under ORS 656.005(7)(a). Claimant credibly testified that on January 18, 1990, while working for the employer, a co-worker threw a defective piece of "core" toward the "throwaway cart." (Tr. 42). Claimant attempted to avoid being hit in the face by the core by twisting and jumping back. (Id.). In doing so, he twisted his left knee. (Id.). Another co-worker, Frank Razee, witnessed the incident and heard claimant complain that he had twisted his knee. (Tr. 12). Razee further testified that prior to the incident, claimant never mentioned any knee problems nor had he ever limped. (Tr. 21). However, Razee testified that after the incident, claimant complained about his knee and "was hobbling around." (Tr. 12). Moreover, Bill Cox, the co-worker who threw the piece of core, testified that after the incident, claimant had problems with his knee. (Tr. 28). Cox further stated that he overheard claimant tell his supervisor later that evening that he had twisted his knee and hurt it. (Tr. 28). In addition, Cox testified that while claimant never mentioned knee problems prior to that incident, claimant had ongoing knee problems after the incident. (Tr. 30, 31).

Additionally, the medical opinions of Dr. Smith, claimant's treating orthopedic surgeon, and Dr. Freudenberg, claimant's consulting orthopedic surgeon, support compensability. Claimant first sought treatment for his knee on August 30, 1990 from Dr. Smith, who noted degenerative changes in claimant's left knee, diagnosed "probable meniscal tear," and referred claimant to Dr. Freudenberg for evaluation. (Ex. 2). Dr. Freudenberg also noted preexisting degenerative changes related to claimant's old tibial fracture and diagnosed "[p]robable degenerative joint disease of the lateral compartment, left knee, with possible superimposed torn lateral meniscus." (Exs. 5-2, 5A). Based on claimant's description of the January 18, 1990 injury and an arthroscopic examination of claimant's knee,

Freudenberg opined that "the findings at arthroscopy were consistent with his history. That is the lateral meniscus tear probably occurred at the time of the reported injury." (Id.). Dr. Smith also opined that claimant's January 18, 1990 injury was the major contributing cause of his meniscus tear. (Ex. 7).

On review, the employer argues prior to the work incident on January 3, 1990, claimant allegedly complained of knee discomfort to Dr. Sharman, his family physician. (Ex. 0-1). The employer argues that because Dr. Smith and Dr. Freudenberg were not aware of this preexisting degenerative problem, their opinions should be given little weight. We disagree. The record establishes that both doctors were aware of the degenerative changes present in claimant's knee. (Exs. 2-1, 5-2). Moreover, we do not consider Dr. Sharman's note significant in light of the fact that Sharman did not examine claimant's knee and claimant did not seek treatment for his knee until after the work incident. (Exs. 0-1, 2, 9-4, 9-6; Tr. 48).

The employer also argues that even if the opinions of Dr. Smith and Dr. Freudenberg are based on accurate or complete information, their opinions are not persuasive because they are framed only in terms of possibility, rather than medical probability regarding causation. We disagree. "Magic words" are not required in order to establish medical causation. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). On the record as a whole, we are persuaded that Dr. Smith's and Dr. Freudenberg's uncontroverted opinions support the conclusion that the January 18, 1990 work incident was a material contributing cause of claimant's meniscus tear and need for surgery. Accordingly, we find that claimant has established a compensable injury claim. See Mark N. Wiedle, supra.

We next consider whether claimant's compensable injury has combined with his preexisting degenerative joint disease to cause or prolong his disability or need for treatment and if so, whether the injury is the major contributing cause of the resultant disability and need for medical treatment. ORS 656.005(7)(a)(B). Based on the uncontroverted medical evidence discussed above, we conclude that both questions should be answered in the affirmative. In reaching this conclusion, we recognize that neither Dr. Smith nor Dr. Freudenberg discussed claimant's preexisting condition. However, we nevertheless find their opinions sufficient to establish compensability. We note that both doctors were aware of claimant's degenerative condition, but neither identified the preexisting condition as a cause of claimant's current disability. Accordingly, we hold that claimant has established the compensability of his claim. See ORS 656.005(7)(a)(B); Bahman M. Nazari, supra.

Attorney Fee at Hearing

The Referee awarded claimant's attorney an assessed fee of $3,400 for services at hearing, which the employer contends is excessive because: (1) the two depositions, which were conducted after the hearing, were short and conducted in claimant's counsel's office; (2) claimant's counsel's failure to be available for closing oral arguments and failure to timely submit written closing arguments created delays; and (3) the amount awarded by the Referee was in excess of that incurred by the employer in defense of this claim.

After review of the record at the hearing, and considering the factors set forth in OAR 438-15-010(4), we conclude that the Referee's award is reasonable. In reaching this conclusion, we have particularly considered the value of the interest involved, the time devoted to the issue, as represented by the hearing record, and the risk that counsel's efforts might go uncompensated.

Attorney Fee on Review

Because the employer initiated the request for review and we have not disallowed or reduced compensation awarded to claimant, claimant is entitled to an assessed fee under ORS 656.382(2). In arriving at a reasonable assessed fee at the Board level, we consider the same factors as above. We conclude that a reasonable assessed attorney fee for claimant's counsel's services 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 also note that claimant did not defend against the employer's effort to reduce the attorney fee awarded by the Referee for which there would be no entitlement to an attorney fee award for such efforts under ORS 656.382(2). Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated October 30, 1991 is affirmed. For services rendered on review concerning the compensability issue, claimant's counsel is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

Board Member Hooton specially concurring.

I agree that claimant has established the compensability of his left knee meniscal tear. I further agree that, if ORS 656.005(7) (a) (B) were applicable to the present dispute claimant would still have established the compensability of his left knee meniscal tear. I write separately only to express my disagreement with the general statement that ORS 656.005 (7) (a) (B) applies to the present dispute.

ORS 656.005 (7) (a) (B) provides in pertinent part as follows:

> "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 added).

Claimant has a preexisting degenerative condition in his left knee. He also has an injury related meniscal tear in the same knee. However, the mere presence of a preexisting disease process is not sufficient to trigger an elevated burden of proof. There must also be some evidence indicting a causal combination of the preexisting condition and the subsequent injury in claimant's current disability or need for medical services. The only evidence which even suggests such a combination is Dr. Freudenberg's description of the meniscal tear as "superimposed" on the preexisting degenerative joint disease.

Webster's Ninth New Collegiate Dictionary (1983) defines the word "superimpose" to mean "to place or lay over or above something." This does not indicate a causal relationship, but rather, a temporal or spacial relationship only. It is not sufficient to require an elevated burden of proof in the present claim.

In the Matter of the Compensation of
WILLARD L. DAY, Claimant
WCB Case Nos. 89-22599, 89-03811 & 89-07816
ORDER ON REVIEW
John E. Uffelman, Claimant Attorney
Susan D. Ebner (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of those portions of Referee Peterson's order that: (1) held that claimant had failed to establish that a March 29, 1989 Determination Order had prematurely closed his abdominal injury claim; (2) increased claimant's unscheduled permanent disability award for a low back injury from 10 percent (32 degrees), as awarded by a November 2, 1989 Determination Order, to 13 percent (41.4 degrees); and (3) decreased claimant's unscheduled permanent disability award for an abdominal injury from 10 percent (32 degrees), as awarded by an April 8, 1991 Order on Reconsideration, to 5 percent (16 degrees). On review, the issues are premature closure and extent of unscheduled disability. We affirm in part and modify in part.

FINDINGS OF FACT

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

Claimant has a high school education. As a result of his compensable low back injury, claimant has only 25 degrees of retained thoracolumbar extension and 25 degrees of retained right and left lateral flexion.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

Claimant challenges the Referee's decision that his abdominal injury claim had not been prematurely closed by the March 29, 1989 Determination Order. Because medical evidence establishes that his abdominal strain aggravated his low back condition in May 1989, he contends that his abdominal injury claim could not be closed until his low back became medically stationary. We disagree.

"Medically stationary" means that "no further medical improvement would reasonably be expected from medical treatment or the passage of time." ORS 656.005(17). In determining whether a claim was prematurely closed, we look to whether the worker's condition was medically stationary on the date of closure, without considering subsequent changes in his condition. Scheuning v. J. R. Simplot & Company, 84 Or App 622 (1987). In this case, the unrebutted medical opinion was that claimant's abdominal condition was medically stationary on February 16, 1989. Moreover, the medical evidence indicates that his condition did not change between that date and March 29, 1989, the date of closure. It was only later when claimant's abdominal strain aggravated his low back condition causing the need for additional treatment.

Extent of Unscheduled 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). OAR 436-35-003(1) provides that the standards set forth in WCD Administrative Order 6-1988 apply to the rating of permanent disability to all claims where the worker became medically stationary prior to July 1, 1990. For claims in which the worker became medically stationary after July 1, 1990, the standards in effect on the date of the Determination Order control the evaluation of permanent partial disability. OAR 436-35-003(2).

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

Low Back Claim

Claimant's low back condition became medically stationary on August 22, 1989. Accordingly, we apply the standards set forth in WCD Administrative Order 6-1988 in rating claimant's permanent disability with regard to that claim. The underlying facts necessary to apply the standards are determined as of the date of the hearing. Tracey A. Fast, 41 Van Natta 835 (1989).

Age and Education

The appropriate value for claimant's age of 45 years is 1. Former OAR 436-35-290.

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

The highest specific vocational pursuit (SVP) level demonstrated by a claimant during the ten years preceding the date of determination is used to determine a value for skills. Former OAR 436-35-300(4). For our purposes, permanent disability is determined on the date of hearing. The position which claimant successfully performed during the ten years preceding the date of hearing, which has the highest specific vocational pursuit (SVP) level, was that of a roofer (DOT # 866.381-010), which has an SVP of 7. Therefore, the appropriate value for skills is 1.

Whether claimant is entitled to a value for training under former OAR 436-35-300(5) turns on whether he 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).

In this case, SAIF contends that claimant is entitled to no value for training, because he had received professional skills training as a building maintenance technician. During subsequent job placement assistance, however, it was discovered that claimant lacked the skills necessary for employment in the building maintenance field. (Ex. 40-3). Under such circumstances, we conclude that, despite completing an authorized training program, claimant has not demonstrated competence in a specific vocational pursuit. Therefore, the appropriate value for training is 1. Former OAR 436-35-300(5).

Adaptability

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

In this case, claimant's usual and customary work required the physical capacity to do heavy work. Claimant's modified work required a light or medium physical capacity. Therefore, the appropriate adaptability value is 2.5. Former OAR 436-35-310(3)(a).

Impairment

Chronic conditions limiting the repetitive use of an unscheduled body part is rated as a 5 percent impairment of that part under former OAR 436-35-320(4). Under the rule, an award for a chronic condition limiting the repetitive use of a body part is available regardless of whether claimant is entitled to impairment values for any other conditions or restrictions. Larry L. McDougal, supra.

In this case, it is undisputed that claimant suffers from a chronic condition that limits the repetitive use of his back. Accordingly, he is entitled to an award of 5 percent impairment for that unscheduled body part. We also conclude that claimant is entitled to an award of .5 percent for 25 degrees of retained thoracolumbar extension, former OAR 436-35-360(7), 1 percent for 25 degrees of retained right lateral flexion, former OAR 436-35-360(8), and 1 percent for 25 degrees of retained left lateral flexion. Former OAR 436-35-360(8). To arrive at a total impairment value, we add the values for lost range of motion for a single value of 2.5 percent, which is then combined with his 5 percent award for chronic condition for a single impairment value of 7.375 percent. Former OAR 436-35-360 (10) and (11).

Computation - Low Back Injury

Having determined each value necessary to compute claimant's permanent disability with regard to his low back claim, we proceed with our calculation. When claimant's age value 1 is added to his education value 2, the sum is 3. When that value is multiplied by claimant's adaptability value 2.5, the product is 7. When that value is added to claimant's impairment value 7.375, the result is 14.375 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability for his low back claim is, therefore, 15 percent.

Abdominal Claim

Claimant's abdominal condition last became medically stationary on July 30, 1990. Because that medically stationary date is after July 1, 1990, amendments to ORS 656.245(3), 656.268(4)-(8) and 656.283(7) apply to this claim. Or Laws 1990 (Special Session), ch. 2, §54(3). Moreover, because this claim was last closed by a September 18, 1990 Determination Order, we again apply the standards set forth in WCD Administrative Order 6-1988. OAR 436-35-003(2).

Age, Education and Adaptability

In rating the extent of claimant's permanent disability resulting from his abdominal injury, the Referee concluded that he could not consider claimant's age, education and adaptability, because those factors were previously taken into consideration in rating claimant's low back injury. He relied on OAR 436-35-007(3), which provides, in part:

> "If a worker has a prior award of permanent disability under the Oregon Workers' Compensation law, the award shall be considered in subsequent claims pursuant to ORS 656.222."

On review, claimant contends that the Referee's reliance on OAR 436-35-007(3) was misplaced, because that rule, contained in WCD Administrative Order 2-1991, is not applicable to this matter. We agree. As noted above, the rules set forth in WCD Administrative Order 6-1988 apply to this claim. Nonetheless, ORS 656.214(5) is applicable and provides that the criteria for rating disability "shall be the permanent loss of earning capacity due to the compensable injury." (Emphasis supplied). In Mary A. Vogelaar, 42 Van Natta 2846 (1990), we analyzed that provision and concluded that an injured worker is not entitled to be doubly compensated for a permanent loss of earning capacity which would have resulted from the injury in question, but which had already been produced by an earlier accident and compensated by a prior award. In that case, we determined the extent of the claimant's unscheduled permanent disability by first determining the extent of disability under the standards. Then, we determined whether, and to what extent, that determination included unscheduled permanent disability which was not due to the current injury because it was already existing before the current injury. Thus, in cases where the claimant has prior unscheduled permanent disability, extent of permanent disability is first determined by an application of the standards, and then by a subsequent consideration of any prior permanent disability awards. See also Alberta M. Lakey, 43 Van Natta 30 (1991).

Accordingly, we first proceed with our determination under the standards. Based on our prior determination of claimant's permanent disability caused by his low back injury, we make the following conclusions as to the following values: age (1), education (0), skills (1), training (1), and adaptability (2.5).

Impairment

Chronic conditions limiting the repetitive use of an unscheduled body part is rated as a 5 percent impairment of that part under former OAR 436-35-320(4). In this case, it is undisputed that claimant suffers from a chronic condition that limits the repetitive use of his abdomen. Accordingly, he is entitled to an award of 5 percent impairment for that unscheduled body part.

Claimant also appears to argue that he is entitled to an additional award of impairment under former OAR 436-35-375, which provides that an award of 5 percent shall be allowed for any injury resulting in permanent damage to the abdominal wall "if the structured weakness of the abdominal wall does not allow lifting of more than ten pounds." However, claimant does not dispute the fact that he is capable of performing medium to light work, which at least includes the ability to lift up to 20 pounds occasionally or up to 10 pounds frequently. Former OAR 436-35-310(4)(c). Accordingly, no award under former OAR 436-35-375 is allowed.

Computation - Abdominal Injury

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 1, is added to his education value, 2, the sum is 3. When that value is multiplied by claimant's adaptability value, 2.5, the product is 7.5. When that value is added to claimant's impairment value, 5, the result is 12.5 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole number. Former OAR 436-35-280(7). Thus, claimant's permanent disability as a result of his abdominal injury is 13 percent.

Application of ORS 656.214(5)

As stated earlier, once we have determined the extent of disability under the standards, we must

determine whether, and to what extent, that determination includes unscheduled permanent disability that previously existed after the original injury. Mary A. Vogelaar, supra. We do so by taking into account whether and to what extent the prior unscheduled disability resulted from the same limitations and vocational factors as claimant's permanent disability determined by the standards with regard to this claim. After our review of the record, we conclude that 5 percent of the abdominal award, determined by the standards, represents permanent disability that previously existed after the low back injury and for which claimant has received compensation. Accordingly, claimant is entitled to an award of 8 percent unscheduled permanent disability as "due to" the abdominal injury claim.

ORDER

The Referee's order dated September 27, 1991 is affirmed in part and modified in part. In addition to claimant's prior awards for his low back injury, claimant is awarded 2 percent (6.4 degrees) unscheduled permanent partial disability as a result of his low back injury, giving him a total award to date of 15 percent (48 degrees). Claimant's attorney is awarded 25 percent of this increased compensation. However, the total fees awarded by the Referee and Board orders shall not exceed $3,800. In lieu of the Referee's award for claimant's adbominal injury, the Order on Reconsideration award of 10 percent (32 degrees) is reduced to 8 percent (25.6 degrees) unscheduled permanent disability. The remainder of the order is affirmed.

In the Matter of the Compensation of
STEVEN D. FRY, Claimant
WCB Case No. 91-05551
ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

The self-insured employer requests reconsideration of our July 8, 1992 Order on Review, which affirmed a Referee's order setting aside its denial of claimant's medical services claim for right knee surgery. In that order, we discounted the opinions of Drs. Thompson and Woolpert, because those opinions were based on the legally impermissible conclusion that claimant's condition, as it existed at the time of his 1987 knee surgery, was no longer related to the 1985 compensable injury.

On reconsideration, the employer argues that our reason for rejecting those opinions is not supported by the record and maintains that neither Thompson nor Woolpert ever said claimant's knee problems in 1987 were unrelated to the 1985 injury.

In his report dated March 14, 1991, Thompson concluded:

> "It would appear from reviewing the record that the need for [the 1987] arthroscopy was not related to the original injury in 1985, but rather to the underlying chondral defects and chondromalacia that preexisted the 1985 injury, that had been aggravated by the activities of football practice in 1986." (Ex. 60-6). (Emphasis supplied.)

From the foregoing, it is clear that Thompson believed that the 1987 arthroscopy was unrelated to the 1985 injury. Moreover, while Woolpert did not make such an explicit statement, he did conclude that the 1985 injury merely aggravated claimant's underlying condition and that the need for surgery in 1987 was more related to his football activities in 1986. (Ex. 62A-3). We infer from those statements that Woolpert also concluded that claimant's knee problems in 1987 were unrelated to the 1985 injury.

Accordingly, our July 8, 1992 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our July 8, 1992 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
CHARLES A. JONES, Claimant
WCB Case No. 91-07822
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Thomas E. Ewing (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Howell's order that: (1) found that claimant's out-of-state physician was not an "attending physician"; (2) found that claimant's proposed surgery was not reasonable and necessary treatment under ORS 656.245; and (3) declined to award a carrier-paid attorney fee. On review, claimant contends that: (1) his physician is an "attending physician"; (2) the proposed surgery should be authorized; and (3) an attorney fee award should be granted. The SAIF Corporation moves to vacate the Referee's order on the basis that the Referee was without original jurisdiction of this matter. We grant SAIF's motion and vacate the Referee's order.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant requested a hearing, contending that SAIF had failed to authorize a total hip replacement surgery proposed by his Idaho physician. SAIF questioned whether the surgery was "medically necessary." (Tr. 9). The Referee upheld SAIF's "de facto" denial, concluding that the proposed surgery was not requested by an "attending physician."

Subsequent to the Referee's order, we held that original jurisdiction over 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" lies exclusively with the Director for review pursuant to ORS 656.327. See Stanley Meyers, 43 Van Natta 2643, 2645 (1991). Moreover, we more recently held that disputes regarding whether or not out-of-state medical treatment has been authorized by an "attending physician" constitutes an issue as to whether the treatment is "in violation of rules regarding the performance of medical services." See Sheila K. Wagner, 44 Van Natta 1079 (1992); see generally Julie M. Harper, 44 Van Natta 820 (1992). Therefore, original jurisdiction of such a matter is with the Director. See id.

Here, like in Wagner, the dispute concerns whether or not claimant's out-of-state medical treatment was authorized by an "attending physician." Specifically, the issue is whether Dr. Colburn, as an out-of-state physician, qualifies as an "attending physician" capable of authorizing compensable medical services. ORS 656.005(12); OAR 436-10-005(1). As we held in Wagner, original jurisdiction over such a dispute lies exclusively with the Director. Because review by the Director pursuant to ORS 656.327 was not sought by either party, the Referee was without jurisdiction to consider this matter. We therefore vacate his order. Furthermore, lacking jurisdiction over this matter, we do not address claimant's assertions that ORS 656.245(3)(b)(A) is unconstitutional under the United States Constitution.

ORDER

The Referee's order dated October 15, 1991 is vacated. Claimant's request for hearing is dismissed.

In the Matter of the Compensation of
CARLA L. MABE, Claimant
WCB Case No. 91-09928
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of Referee Crumme's order that set aside its denial of claimant's claim for a low back injury. Claimant cross-requests review, seeking penalties and attorney fees. On review, the issues are remand, compensability and penalties and attorney fees.

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

In her respondent's brief, claimant has submitted information, not presented at hearing, concerning medical bills she asserts were not paid. Claimant submits this evidence in order to show that there were amounts due on which to base a penalty. We treat submission of this additional evidence as a motion for remand. Judy A. Britton, 37 Van Natta 1262 (1985).

The Board's review is limited to the record developed by the Referee. We may remand to the Referee for the taking of additional evidence if we determine that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 56.295(5).

To merit remand, however, it must be shown that the evidence was not obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986). Here, no showing of due diligence has been made. Claimant's hearing request sought penalties and attorney fees and yet, no evidence was offered at hearing that any medical bills were submitted to the insurer and were not paid. Claimant asserts that the Referee failed to hold the record open for receipt of evidence of unpaid compensation. The record, however, reveals that no such request was ever made. Based on this record, we conclude that claimant has not shown that the evidence could not have been obtained with due diligence at the time of hearing. Therefore, remand is not warranted. Accordingly, we decline to consider the additional information contained in claimant's brief.

Claimant next contends that she is entitled to an attorney fee pursuant to ORS 656.382(1). In this regard, claimant asserts that the insurer's request for Board review is frivolous and constitutes "unreasonable resistance" to the payment of compensation. Claimant cites SAIF v. Curry, 297 Or 504 (1984) in support of her request. In Curry, the court discussed and applied ORS 656.382(2), not the penalty-related fee provision contained in ORS 656.382(1). Therefore, Curry is not pertinent here. Finally, we have previously held that the authority for the assessment of a penalty and related fee for a vexatious, unreasonable, or frivolous request or appeal vests with the Referee or the court, not this Board. Verl E. Smith, 43 Van Natta 1107 (1991): Donald G. Messer, 42 Van Natta 2085 (1990).

In any event, since claimant had suffered a prior injury and since witnesses testified that claimant complained about having back pain before the February 12, 1991 injury occurred, the insurer's request for review cannot be regarded as frivolous (without any foundation in fact or law). See Taylor v. Multnomah County School Dist. No. 1, 109 Or App 499 (1991). (The increased pain the claimant experienced was a symptomatic exacerbation of a prior injury rather than a new injury).

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 $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 November 14, 1991 is affirmed. For services on review, claimant's attorney is awarded $1,000, to be paid by the insurer.

In the Matter of the Compensation of
ORVAL R. OGBIN, Claimant
WCB Case Nos. 91-11151 & 91-11547
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

The self-insured employer requests review of Referee Livesley's order that increased claimant's scheduled permanent disability award from 24 percent (14.4 degrees) for hearing loss in the left ear to 44.53 percent (85.5 degrees) for hearing loss in both ears. In its appellant's brief, the employer asserts that: (1) the Referee lacked jurisdiction to consider the extent of claimant's scheduled permanent disability; (2) claimant is not entitled to an increased award; and (3) the Referee applied the wrong standards in determining extent of permanent disability. On review, the issues are jurisdiction and extent of scheduled permanent partial disability. We vacate.

FINDINGS OF FACT

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

In its cross-request for reconsideration of the Determination Order, the employer objected to the attending physician's impairment findings. The Director did not appoint a medical arbiter and findings by a medical arbiter were not considered during the reconsideration process.

CONCLUSIONS OF LAW AND OPINION

ORS 656.268(7) requires the Director to refer a claim to a medical arbiter if a party's objection on reconsideration to a notice of closure or determination order is based on a disagreement with the impairment used in rating the worker's disability. We have held that, under this statute, an Order on Reconsideration is invalid if the basis for objection is to the impairment findings and the Director fails to appoint a medical arbiter and submit the arbiter's findings for reconsideration. See Olga I. Soto, 44 Van Natta 697, 700 (1992). However, in determining whether the basis for objection is disagreement with the impairment findings used in rating the worker's disability, we distinguish between an objection to the actual findings of impairment by the attending physician, and an objection to the application or interpretation of the attending physician's impairment findings to determine the award of permanent disability. See Doris C. Carter, 44 Van Natta 769, 770 (1992). Only in the first instance do we find that the Order on Reconsideration is invalid and that we lack jurisdiction to consider the request for hearing from the Order on Reconsideration.

Here, we find that claimant's request for reconsideration was based on a disagreement with the application of the attending physician's findings. His request checked "No" to box number 4, indicating that he did not disagree with the impairment findings of the attending physician, Dr. Tate. (Ex. 8-2). Moreover, the cover letter recited Dr. Tate's findings of a "38.75 percent hearing loss on the right [ear] and 85 percent hearing loss on the left [ear], which corrects to a 44.53 binaural hearing loss," further indicating that claimant was relying on Dr. Tate's findings to object to the Determination Order. (Id. at 1).

The employer, however, filed a cross-request for reconsideration. In that request, the employer asserted that the Determination Order was based on inapplicable standards. (Ex. 10-1). The employer further requested that:

"the Appellate Unit carefully scrutinize the relative validity of hearing loss measurement in this matter as distinguished between the examiners, Drs. Tate and Ediger [who conducted an independent medical examination], and reference those examinations back to the history of audiograms taken over the preceding many years in this file.

"I attached for you the complete medical record, including the history of audiograms from 1975 forward. As you can see, Dr. Tate's conclusions in October of 1990 are far out of line with the other audiograms taken in this matter." (Id. at 2).

We find that the employer's cross-request for reconsideration in part was based on a disagreement with the impairment findings of Dr. Tate. The employer asked the Director to examine Dr. Tate's findings in comparison with those of Dr. Ediger and previous audiogram results, stating that Dr. Tate's conclusions "are far out of line" with previous audiograms. We construe this statement to constitute disagreement with Dr. Tate's impairment findings; it is not simply an objection to the application of his findings in determining claimant's permanent disability. Thus, in the absence of appointment of a medical arbiter by the Director or submission of a medical arbiter's findings during the reconsideration process, the Order on Reconsideration is invalid. See Olga I. Soto, supra. Consequently, the Referee lacked jurisdiction to consider the employer's request for hearing and claimant's cross-request for hearing and we vacate his order.

ORDER

The Referee's order dated December 11, 1991 is vacated. The self-insured employer's request and claimant's cross-request for hearing are dismissed for lack of jurisdiction.

July 31, 1992 Cite as 44 Van Natta 1567 (1992)

In the Matter of the Compensation of
AGNES C. RUSINOVICH, Claimant
WCB Case No. 91-04808
CORRECTED ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Charles Lundeen, Defense Attorney

It has come to our attention that our July 29, 1992 order contained a clerical error. Specifically, the order neglected to state that we adopted the Referee's conclusions and reasoning concerning the extent of disability with the supplementation contained in our order. To correct this oversight, we republish our July 29, 1992 order with the aforementioned supplementation. The parties' rights of appeal shall continue to run from the date of our July 29, 1992 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARLIN L. SAMMS, Claimant
WCB Case No. 90-06347
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys
C. Douglas Oliver (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of those portions of Referee Lipton's order that: (1) set aside its May 29, 1990 partial denial of claimant's headache condition; (2) set aside its May 29, 1990 denial of claimant's aggravation claim; and (3) awarded claimant an assessed attorney fee for his counsel's services in setting aside the allegedly unreasonable denials. Claimant cross-requests review of those portions of the order that: (1) upheld SAIF's November 20, 1990 partial denial of claimant's psychogenic pain disorder condition; (2) upheld SAIF's November 19, 1990 partial denial of claimant's adjustment disorder condition; and (3) declined to set aside as premature a March 7, 1990 Notice of Closure. On review, the issues are compensability, aggravation, premature closure, 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," with the exception of the first and second sentences of the last paragraph of that section. In addition, we clarify and supplement with the following.

Claimant, a welder, began working for the insured in November 1987. He sustained a compensable neck injury in August 1988. Dr. Morgan, claimant's treating physician, diagnosed cervical strain, neck pain, severe headaches, and radicular upper extremity symptoms. Dr. Mason, consulting neurosurgeon, has examined claimant on several occasions and concurs in Dr. Morgan's diagnoses.

Claimant was examined by the Orthopaedic Consultants in January 1990; they diagnosed headaches as a part of claimant's cervical strain symptom complex.

SAIF closed claimant's claim by Notice of Closure dated March 7, 1990, rather than February 28, 1990. On March 20, 1990, claimant requested a hearing on the Notice of Closure.

After SAIF's May 29, 1990 denial of claimant's headache and aggravation claims, claimant added those issues for consideration at hearing.

On July 23, 1990, claimant filed claims for psychogenic pain and adjustment disorders. SAIF denied these claims on November 20, 1990; claimant then further amended his hearing request. The hearing was held on December 3, 1990.

Claimant has a preexisting psychogenic pain disorder. The compensable injury is not the major contributing cause of the onset or worsening of his psychogenic pain disorder or need for treatment.

Claimant has a preexisting adjustment disorder. The compensable injury was not the major contributing cause of the onset or worsening of his adjustment disorder or need for treatment.

Claimant's post-injury headache condition arose as a direct consequence of the industrial accident. Claimant's industrial accident was a material contributing cause of the onset of his post-injury headache condition and need for treatment.

Claimant's compensable conditions were medically stationary at the time of claim closure.

Claimant's headache condition worsened after claim closure. The worsening of claimant's headache condition was due to his preexisting psychogenic pain disorder. Claimant's worsened headache condition is unrelated to and did not result from the compensable injury.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that the hearing was convened after July 1, 1990. Accordingly, we analyze this matter under the Workers' Compensation Law effective July 1, 1990. See Or Laws 1990 (Special Session), ch. 2, sect. 54(2); Ida M. Walker, 43 Van Natta 1402 (1991).

Compensability/Psychogenic Pain Disorder and Adjustment Disorder

Claimant contends that he has a psychogenic pain disorder caused in major part by the compensable injury. The unrebutted medical evidence is that claimant's psychogenic pain disorder preexisted the compensable August 1988 cervical injury. Claimant also contends that the compensable injury was the major contributing cause of the worsening of his long-standing, preexisting adjustment disorder.

A worker who suffers a compensable injury, yet 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 insofar as the compensable injury is the major contributing cause of that particular disability or need for treatment. Thus, although the injury is compensable, a worker may not be entitled to claimed compensation for particular medical services or disability if the preexisting disease or condition is the major contributing cause of that disability or need for medical services. ORS 656.005(7)(a)(B); See Bahman M. Nazari, 43 Van Natta 2368 (1991).

The only psychiatric opinion in the record is that of independent examiner Dr. Hughes. The Orthopaedic Consultants and Dr. Hughes performed extensive examinations of claimant in May and June 1990. Dr. Hughes observed the physical examination performed by the Consultants and then conducted a thorough psychiatric evaluation.

Noting that claimant's pain complaints were disproportionate to the actual physical findings he observed on examination, Dr. Hughes diagnosed, inter alia, a preexisting psychogenic pain disorder superimposed on the compensable cervical injury. At his deposition, the doctor explained that a diagnosis of psychogenic pain disorder is indicated when there is preoccupation with pain in the absence of adequate physical findings to account for the pain or its intensity. Dr. Hughes does not deny that claimant's psychogenic pain disorder has become a part of claimant's total medical problem. However, based upon a thorough examination, review of the medical records, and claimant's history, he persuasively testified that antecedent events, rather than the work injury, are the major contributing cause of claimant's psychogenic pain disorder. There is no contrary medical opinion. Consequently, claimant has not established the compensability of his psychogenic pain disorder.

Claimant also contends that his long-standing, preexisting adjustment disorder was worsened by the compensable injury. Dr. Hughes confirms this diagnosis, and explains that claimant's adjustment disorder stems from such past events as his reactions to his parents' divorce, problems in school, caring for himself at an early age, and his own divorce leading to a brief period of alcohol abuse. Further, Dr. Hughes unequivocally testified that, although the compensable injury required claimant to adjust to a new situation, claimant's underlying adjustment disorder was not materially altered or changed by the compensable injury. Again, there is no opinion to the contrary. Consequently, because claimant has not established that the compensable injury was even a material contributing cause of a worsening of his preexisting adjustment disorder, this condition likewise is not compensable.

Compensability/Headaches

Finding that claimant's post-injury headache condition directly resulted from the compensable neck injury, the Referee set aside SAIF's denial. We affirm the Referee's decision with the following comment.

Amended ORS 656.005(7)(a)(A) provides:

> "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."

However, a "consequential" injury does not include conditions directly, though belatedly, related to the original compensable event. See Julie K. Gasperino, 43 Van Natta 1151 (1991), (aff'd Albany General Hospital v. Gasperino, 113 Or App 411 (1992). As we explained in Gasperino, "consequential conditions" are those which are not intrinsically related to or a primary consequence of the original accident or injury itself. Or, as the court stated: "The distinction is between a condition or need for treatment that is caused by the industrial injury, for which the material contributing cause standard still applies, and a condition or need for treatment that is caused in turn by the compensable injury. It is the latter that must meet the major contributing cause test." (Emphasis in original.) Albany General Hospital v. Gasperino, supra, at 415. Here, claimant's headache condition was one of several "primary consequences" of the industrial accident. Therefore, the compensability of this claim is properly analyzed under the material contributing cause standard. See Mark N. Wiedle, 43 Van Natta 855 (1991).

On review, SAIF argues that claimant's headache condition is a result of his noncompensable psychological condition. Therefore, it contends, a ruling that claimant's headache condition is compensable is inconsistent with a ruling that claimant's psychogenic pain disorder is not compensable. In support of its position, SAIF urges us to rely on the May and June 1990 reports of the Orthopaedic Consultants and psychiatrist Hughes. SAIF's argument has merit as it pertains to claimant's aggravation claim, as discussed below. However, the evidence establishes that claimant has a compensable headache condition.

The Consultants and Dr. Hughes concluded that claimant's worsened headache pain after March 12, 1990 was due to noncompensable psychological factors. However, their opinions primarily address claimant's condition after claim closure, and are most relevant to claimant's aggravation claim. See Kienow's Food Stores v. Lyster, 79 Or App 416, 421 (1986).

Instead, we rely on the opinions of Dr. Morgan, claimant's treating physician, and Dr. Mason, consulting neurosurgeon. See Argonaut Ins. v. Mageske, 93 Or App 698, 702 (1988). Dr. Morgan has treated claimant's neck injury since the August 1988 accident, and has consistently diagnosed cervical strain, neck pain, severe headaches, and radicular upper extremities symptoms. Dr. Mason, has examined claimant on several occasions for Dr. Morgan; his diagnoses are essentially the same. Moreover, during their January 1990 examination, the Consultants also diagnosed headaches as a part of claimant's cervical strain symptom complex.

On this record, we find that the August 1988 accident was a material contributing cause of claimant's headache condition and need for treatment. Thus, claimant has established the compensability of his headache condition as a primary/direct consequence of the original injury itself.

Aggravation

Finding that claimant "has demonstrated a worsening subsequent to the last award or arrangement of compensation benefits," the Referee concluded that claimant's aggravation claim for his worsened headache condition is compensable. We reverse.

As amended, ORS 656.273(1) provides in pertinent part that an aggravation claim is a claim for "worsened conditions resulting from the original injury." A worsening of a condition that is unrelated to a compensable condition cannot be the basis of an aggravation claim. See Argonaut Ins. Co. v. Rush, 98 Or App 739 (1989).

After claimant's headache condition worsened in March 1990, he was examined for a second time by the Orthopaedic Consultants, with psychiatrist Hughes observing. The Consultants noted subjective pain complaints out of proportion to the objective findings. Whereas in January 1990 the Consultants had diagnosed cervical strain, chronic neck pain, and headaches, their primary diagnosis was now pain behavior.

Dr. Hughes then performed a thorough mental evaluation. Based on his examination findings and the disproportionate pain responses he observed during the Consultants' examination, Dr. Hughes concluded that claimant's worsened headache pain was due not to organic causes, but rather to a psychogenic pain disorder, which increases the perception of pain. For claimant's worsened pain to support an aggravation claim, his psychogenic pain disorder must be compensable. Claimant's

disproportionate pain cannot form the basis of a compensable aggravation claim, however. As we have found herein, claimant's psychogenic pain disorder is not compensable. Thus, claimant has not established that his worsened headache condition resulted from the original injury. See Argonaut Ins. Co. v. Rush, supra.

Accordingly, consistent with our conclusion that claimant's psychogenic pain disorder is not compensable, we find that claimant's aggravation claim is likewise not compensable.

Premature Closure

We affirm the Referee's conclusion that claimant's claim was not prematurely closed with the following comment.

An injured worker is considered medically stationary when no further material improvement of the compensable condition would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). It is claimant's burden to establish that he was not medically stationary when the claim was closed. Berliner v. Weyerhaeuser, 54 Or App 624 (1981). We evaluate claimant's condition and the reasonable expectation of improvement as of the date of closure. Alvarez v. GAB Business Services, 72 Or App 524 (1985). The 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).

In September 1989, Dr. Morgan reported to SAIF that claimant had returned to part-time light duty work two months earlier. However, because claimant continued to have neck discomfort, Dr. Morgan decided to defer assessment of claimant's medically stationary status until such time as claimant had worked in a full-time position for two to three months.

On January 25, 1990, the Orthopedic Consultants examined claimant. Claimant's neurological examination was essentially normal; the Consultants noted only some minimal restriction of neck motion. They opined that claimant's condition was medically stationary, and that he could return to work at his usual job. Dr. Mason, claimant's neurosurgeon, concurred. Thereafter, SAIF closed the claim by Notice of Closure on March 7, 1990, finding claimant medically stationary on January 25, 1990.

In July 1990, Dr. Morgan wrote SAIF and reiterated that in accordance with his earlier report, he had deferred assessment of claimant's medically stationary status until such time as claimant had returned to work successfully. Further, he noted that he had authorized time loss up through claimant's return to work on February 16, 1990. Therefore, Dr. Morgan advised, he did not consider claimant medically stationary prior to the March 1990 Notice of Closure. However, Dr. Morgan provided no medical findings to support his statement that claimant was not medically stationary in January 1990, or to rebut the findings of the Consultants. We do not find Dr. Morgan's conclusory opinion to be persuasive.

Claimant has not met his burden to establish that he was not medically stationary when the claim was closed.

Attorney Fees at Hearing and On Review

In light of our conclusions, we modify the Referee's $5,000 attorney fee award for prevailing against SAIF's denial of both the compensability of claimant's headache condition and claimant's aggravation claim. As a result of our decision, claimant is entitled to an attorney fee only for prevailing against the employer's denial of his headache condition. ORS 656.386(1). In addition, although claimant did not prevail on his cross-request for review, claimant is entitled to an attorney fee for services on Board review concerning his successful defense of that portion of the Referee's order that set aside SAIF's denial of his headache 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 attorney fee for claimant's counsel's services at the hearing level and on Board review concerning the compensability of claimant's headache condition is $2,750, to be paid by the SAIF Corporation. This fee is in lieu of, rather than in addition to, the Referee's $5,000 attorney fee award. In reaching this conclusion, we have 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 March 4, 1991 is affirmed in part, reversed in part, and modified in part. That portion of the order that set aside the SAIF Corporation's May 29, 1990 denial, insofar as it denied claimant's aggravation claim, is reversed. SAIF's aggravation denial is reinstated and upheld. The Referee's attorney fee award is modified. In lieu of the Referee's $5,000 attorney fee award, for services at hearing and on review concerning the compensability of claimant's headache condition, claimant's counsel is awarded a reasonable assessed fee of $2,750, to be paid by SAIF. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
RODNEY J. THURMAN, Claimant
WCB Case No. 91-08522
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

The self-insured employer requests review of those portions of Referee Bethlahmy's order that: (1) set aside its "back-up" denial of claimant's occupational disease claim for a left wrist condition; and (2) assessed an attorney fee for an unreasonable denial. In its brief, the employer has enclosed a copy of a 1502 form not contained in the record and requests the Board to take administrative notice of the document. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

Claimant worked as a scarfer for the employer. His work involved removing defects from steel by using a torch, and it required repetitive turning and twisting of the wrist. In September 1990, he noticed diminished strength in his left hand and shooting pain in his left wrist and forearm. He did not seek medical treatment at that time.

On February 17, 1991, claimant was terminated from his job. On February 20, 1991, he sought treatment for his left hand symptoms and filed a claim with the employer. He was examined by Dr. Jacobson, a neurologist, who conducted a nerve conduction study and found evidence of mild left carpal tunnel syndrome. On March 14, 1991, claimant began reporting right hand pain. He returned to Jacobson for bilateral nerve conduction studies, which proved consistent with bilateral carpal tunnel syndrome.

On April 29, 1991, claimant was examined by a panel of physicians at the offices of the Orthopaedic Consultants. They found no clinical evidence of carpal tunnel compression and diagnosed bilateral tendinitis.

On May 17, 1991, claimant filed a claim for his right wrist complaints. The employer denied the claim, asserting that there was insufficient evidence that the right wrist condition arose in the course of his employment.

Meanwhile, the employer closed claimant's left wrist claim pursuant to a May 30, 1991 Notice of Closure, which awarded benefits only for temporary disability. The Notice of Closure was subsequently rescinded by a July 22, 1991 Order on Reconsideration, which found that the left wrist claim had been prematurely closed.

On August 23, 1991, claimant was examined by Dr. Button, a hand surgeon, who diagnosed bilateral carpal tunnel syndrome and recommended surgery. Button also noted that although claimant

reported that he had not worked since being terminated, his hands were heavily callused, which suggested that he had been performing heavy work.

On September 17, 1991, the employer issued a "back-up" denial of claimant's previously accepted left wrist claim, asserting that additional information has been obtained indicating that his left wrist condition, diagnosed as carpal tunnel syndrome, is not compensable.

Claimant worked as a roofer prior to his work employment as a scarfer. Claimant periodically worked as a roofer following his termination in February 1991.

CONCLUSIONS OF LAW AND OPINION

The employer seeks review of the Referee's order holding it responsible for claimant's left carpal tunnel syndrome condition, because it had previously accepted the claim and had not established that the claim is not compensable under ORS 656.262(6).[1] We affirm.

ORS 656.262(2) 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 * * * the insurer or self-insured employer may revoke the claim acceptance and issue a formal notice of claim denial. However, if the worker requests a hearing on such denial, the insurer or self-insured employer must prove by clear and convincing evidence that the claim is not compensable[.]"

On review, the employer argues that ORS 656.262(6) does not apply, because it never accepted claimant's left carpal tunnel syndrome. It contends that its acceptance of the claim was limited to "left wrist tendonitis," as noted on a 1502 form appended to its brief. Accordingly, it contends that claimant was required to prove the compensability of the condition by a preponderance of the evidence under ORS 656.266. In response, claimant argues that the 1502 form was obtainable at the time of hearing but was not presented to the Referee and is not part of the record. Therefore, he argues that we cannot consider the document on review, and that a review of the proper record establishes that the employer accepted his left carpal tunnel syndrome.

Claimant is correct that we have no authority to consider additional evidence not admitted at the hearing and not a part of the record. ORS 656.295; Groshong v. Montgomery Ward Co., 73 Or App 403 (1985). We may, however, take official notice of any fact that is "capable of accurate and ready determination by resort to sources whose accuracy cannot be readily questioned." ORS 40.065(b). We have previously taken official notice of determination orders and prior approved stipulations on a claim. See e.g. Grace B. Simpson, 43 Van Natta 1267 (1991); Rita M. Duncan, 42 Van Natta 1854 (1990). In Susan Teeters, 40 Van Natta 115 (1988), we also held that it is proper to take judicial notice of a request for hearing where it has only procedural significance that enables the evaluation of evidence.

We have not previously addressed the propriety of considering an insurer's prepared 1502 form that is not contained in the record. The employer argues that because it is filed with the Department of Insurance and Finance, it is no different than a determination order and also should be subject to official notice. The employer fails to recognize, however, that, unlike a 1502 form, which is prepared by an insurer, a determination order is an act of a state agency, which is expressly subject to judicial notice under ORS 40.090(2). Moreover, while the 1502 form may be contained in the Department's files, we conclude that it should not be judicially noticeable. Unlike the request for hearing in Susan Teeters, supra, the 1502 form in this case constitutes evidence that contains pivotal facts. To accept those facts from a source not subject to confrontation and cross-examination would accomplish exactly what the court criticized in Groshong v. Montgomery Ward Co., supra:

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[1] The Referee also concluded that claimant had failed to establish the compensability of his right carpal tunnel syndrome, because his work activities were not the major contributing cause of the condition. Neither party disputes that conclusion on review.

> "'The vice of receiving these "facts" as evidence outside of the hearing is that it deprives petitioner of an opportunity to challenge them. Without presentation at hearing, petitioner has no way of showing that these facts--which carry much weight--either are not well founded or are not relevant to his case for some distinguishing reason.'" 73 Or App at 408, quoting Rolfe v. Psychiatric Security Review Board, 53 Or App 941 (1981).

Accordingly, we deny the employer's request to take official notice of the appended 1502 form. We exclude the document and do not consider it in determining whether the employer has accepted claimant's carpal tunnel syndrome.

Whether an acceptance occurs is an issue of fact, to be decided on a case-by-case basis. SAIF v. Tull, 113 Or App 449 (1992). In this case, claimant filed an 801 form claiming left wrist pain. Although the employer did not officially notify claimant of an acceptance, it provided benefits and closed the claim by way of a May 30, 1991 Notice of Closure. Although the Orthopaedic Consultants diagnosed left wrist tendonitis, we find the preponderance of the medical evidence to establish that the disease which caused claimant's wrist pain was left carpal tunnel syndrome. The employer appears to acknowledge that condition in its "back-up" denial, which identifies carpal tunnel syndrome as the cause of claimant's left wrist problem. Under these circumstances, we conclude that the employer accepted claimant's claim for claimant's left carpal tunnel syndrome.

After our review of the record, we also conclude that the employer has failed to establish by clear and convincing evidence that the claim is not compensable as required by ORS 656.262(6). Soon after claimant stopped work, nerve conduction studies revealed mild abnormalities and evidence of left carpal tunnel syndrome. Dr. Jacobson, who conducted the studies, attributed the condition to the repetitive movements of claimant's work as a scarfer. While the employer subsequently obtained evidence that claimant was working as a roofer, and that such work may have caused the further development of his condition, we do not find that evidence to be clear and convincing proof that the original condition is not compensable.

Attorney Fee--Unreasonable Denial

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

Attorney Fee on Review

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 compensability issue is $1,250, 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 November 6, 1991 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,250, to be paid by the self-insured employer.

In the Matter of the Compensation of
CLAYTON J. UPHOFF, Claimant
WCB Case No. 91-08227
ORDER ON REVIEW
Sellers & Jacobs, Claimant Attorneys
Thomas J. Castle (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Leahy's order which: (1) found that his hearing request was barred as untimely; and (2) upheld the SAIF Corporation's denial of his injury/occupational disease claim for an inguinal hernia. On review, the issues are timeliness of claim filing and compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

Claimant's claim was filed more than 30 days after his alleged injury. SAIF was not prejudiced thereby.

CONCLUSIONS OF LAW AND OPINION

Timeliness

The Referee concluded that claimant's injury claim was barred because he filed his claim more than 30 days after the alleged December 10, 1990 work incident and SAIF's ability to investigate the claim was consequently prejudiced by the late filing. We disagree.

ORS 656.265(1) and (4) provide that failure to give notice to the employer within 30 days after an injury bars an injured worker's claim if the delay results in prejudice. Inkley v. Forest Fiber Products Co., 288 Or 337 (1980). An insurer bears the burden of proving prejudice. Id. "The mere passage of time is not sufficient to show prejudice; the employer must prove some actual prejudice." Grimes v. SAIF, 87 Or App 597, 601 (1987); Ford v. SAIF, 71 Or App 825, 828, rev den 299 Or 118 (1985). Moreover, there must be facts, not mere conclusory statements or speculation, in order to establish prejudice. Nat'l Farmers Union Ins. v. Scofield, 57 Or App 23 (1982).

In the present case, SAIF points to Dr. Heinonen's report as proof that claimant's failure to give timely notice of his alleged injury prejudiced SAIF by depriving it of the opportunity to timely investigate the claim. Dr. Heinonen reported:

> "There is no way to prove or disprove that this hernia did happen on December 10, 1990 although I think it very unusual that medical attention was not sought sooner than two months after the fact and there was no time loss immediately after this incident." (Ex. 9).

We do not find this statement sufficient to establish that SAIF's investigation of the claim was prejudiced. At best, the statement is speculative. Moreover, taken in the context of the entire report, Dr. Heinonen's statement suggests only that his ability to pinpoint the exact date of the injury may have been somehow hampered by claimant's failure to seek medical attention until February 22, 1991. It does not, however, establish prejudice. Consequently, considering the record as a whole, we find that SAIF has failed to establish that its investigation of the claim was prejudiced by the untimely filing. See Aetna Casualty Co. v. Kupetz, 106 Or App 670 (1991); Garry D. Smith, 44 Van Natta 322 (1992). Accordingly, we conclude that claimant's injury claim is not time-barred and we address the issue of compensability.

Compensability

At hearing, claimant advanced both an occupational disease and an injury theory, asserting that his inguinal hernia was caused either by his work activities or by a work-related incident. As to the occupational disease claim, the Referee concluded that claimant had failed to establish that his work activities were the major contributing cause of his hernia. We affirm and adopt that portion of the Referee's order.

As to claimant's injury claim, under ORS 656.005(7)(a), claimant bears the burden of proving that a work injury was a material contributing cause of his disability or need for treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991). In view of the lengthy time period between the date of claimant's alleged injury and the date he sought treatment and filed a claim, we find that the cause of his hernia 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).

Dr. Duckler, claimant's treating surgeon, rendered no opinion as to whether the hernia was work-related. (Exs. 1, 4, 5, 7). Consequently, the only medical opinion addressing the causation issue is that of Dr. Heinonen, who conducted an independent review of claimant's medical records. Heinonen opined that claimant's hernia could have been congenital or caused by some vigorous activity. (Ex. 9). He further stated, however, that if it was caused by vigorous activity, claimant would likely have developed severe pain and sought medical treatment long before he did. (Id.). Based on this medical evidence, we conclude that claimant has failed to prove his claim.

ORDER

The Referee's order dated October 28, 1991 is reversed in part and affirmed in part. That portion of the Referee's order which found that claimant's injury claim was barred for untimely filing is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
DAVID M. VANASEN, Claimant
WCB Case Nos. 90-20560 & 90-07460
ORDER ON REVIEW
Kenneth Bourne, Claimant Attorney
Roberts, et al., Defense Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Moller and Westerband.

United Pacific Insurance (United) requests review of Referee Tenenbaum's final order that: (1) set aside its denial of claimant's medical services claim for his current low back condition; and (2) upheld the SAIF Corporation's "de facto" denial of claimant's aggravation claim for the same condition. We also review Referee Tenenbaum's interim order upon which her final order was based and which necessarily became a part of that final order for review purposes. On review, SAIF requests that, if the Board reverses the Referee's finding regarding the Stipulated Order, the case be remanded to the Hearings Division. The issue on review is responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact found in her interim and final orders.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's conclusions with the following supplementation.

Because the hearing was convened after July 1, 1990, claimant's claim is properly analyzed under the 1990 revisions to the Workers' Compensation Act. See Ida M. Walker, 43 Van Natta 1402 (1991). As relevant, 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 ORS 656.308(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).

Here, the question of responsibility turns on whether SAIF's October 1987 stipulated acceptance of claimant's "new injury" claim is binding on SAIF. It is undisputed that SAIF accepted claimant's "new injury" claim on behalf of a putative noncomplying employer. However, the Department's Proposed and Final Order which found the employer to be noncomplying was reversed by an Opinion and Order issued by Referee Mulder after SAIF's acceptance of the claim. In reversing the Department's order, Referee Mulder found that claimant was an independent contractor rather than a subject worker when he allegedly sustained the new injury while working with the employer. That order was not appealed and has become final by operation of law. United, the original carrier, contends that SAIF is bound by its stipulated acceptance of the new injury claim, and consequently, responsibility shifted upon that acceptance from United to SAIF pursuant to ORS 656.308(1).

In the present case, Referee Tenenbaum rejected United's argument, stating that:

> "* * * Once Referee Mulder's Opinion and Order [in the noncomplying employer matter] was final, claimant was entitled to no additional benefits in the workers' compensation system, as [sic] least as a result of a claimed new injury in October 1985.
>
> "As a matter of law, claimant was only entitled to benefits until the determination was made that he was not a subject worker. There is no evidence claimant gave up anything by signing the stipulation. * * *
>
> "While claimant may have relied on the stipulation, in the sense that he became accustomed to SAIF paying the bills and other benefits of workers' compensation, he had no legal right to rely on anything more than SAIF's processing until the duty to process ended.
>
> "The workers' compensation system is a creature of statute. SAIF's duty to process claims made against noncomplying employers cannot be extended beyond the statutory authority." (Interim Order, p. 2)

We agree with Referee Tenenbaum's conclusion. In reaching that conclusion, the Referee relied on our decision in Juan Garcia, 42 Van Natta 2632, on recon 42 Van Natta 2797 (1990). There, SAIF also entered into a stipulated acceptance on behalf of a putative noncomplying employer. As here, the Department's Proposed and Final Order was eventually reversed by a Referee and no further appeal was taken. We concluded that when the Referee's order became final, SAIF was not bound by its stipulated acceptance of the claim.

However, the Board's decision in Garcia was itself reversed by the Court of Appeals in a decision rendered while the present case was pending Board review. Garcia v. SAIF, 108 Or App 653 (1991). Thus, we must decide whether the court's analysis and decision compel us to conclude that SAIF is bound by its stipulated acceptance in the present case.

After careful examination of the court's decision in Garcia, it remains our conclusion that SAIF is not bound by the stipulation. Indeed, we find the Garcia case clearly distinguishable on its facts and that the court's decision lends support to (rather than brings into doubt the validity of) the conclusion we have reached.

In Garcia, it was undisputed that the claimant had sustained a compensable injury while working at Basin Farms and that he was a subject worker as well. The seminal problem in the case was that the Department identified the wrong individual as the employer and determined that he was noncomplying for failure to carry insurance. The Department referred the claim to SAIF for processing on behalf of the individual it had erroneously identified, pursuant to ORS 656.054. SAIF accepted the claim by stipulation on behalf of that person, without making an effort to determine which of two persons involved at the Farm was actually the claimant's employer.

Pursuant to the stipulation, the claimant's hearing request against the wrongly identified person was dismissed with prejudice. Subsequently, and for reasons not apparent from the record, his hearing requests against the other potential employer were also dismissed. Meanwhile, the person erroneously identified as the employer requested a hearing concerning the noncomplying employer determination.

The claimant did not appear at that hearing because he relied on SAIF's acceptance of his claim. After the hearing, the Referee reversed the Department's order which had misidentified the employer and found him to be noncomplying, on the grounds that he was not the claimant's employer. Thereafter, SAIF unilaterally terminated the claimant's benefits on the claim. The claimant requested a hearing and a Referee reinstated SAIF's acceptance and imposed penalties for unreasonable claims processing.

On review, the Board reversed the Referee, citing the basic rule that if the insurer did not provide coverage to the employer on the date of injury, there is no basis for payment and the insurer may lawfully issue a back-up denial. The court, however, disagreed with the Board. The court found that, on the facts of the case, an exception was called for to the basic rule that permits back-up denials where coverage is lacking. The court explained:

> "* * * [T]he rule in Bauman v. SAIF, 295 Or 788, 670 P2d 1027 (1983), prohibiting back-up denials, was not intended to prevent a denial of a previously accepted claim when the insurer discovers that it did not provide coverage to the employer on the date of the injury. If there is no coverage, there is no basis for payment, and the insurer cannot be held accountable. However, the situation here is different: In the two cases cited, the dispute was between insurance companies; the claimant's right to compensation was not at risk. Here, a denial of coverage under the circumstances created by SAIF would result in a loss of benefits to claimant for an injury that no one disputes arose out of his employment.
>
> "Claimant satisfied his obligation under the workers' compensation statutes by filing claims with each of the two entities potentially responsible for his injury. Having done that, he had no other duty to establish that his injury was related to his employment. When the Compliance Section called upon SAIF to process the claim against [the putative employer], SAIF had the duty to investigate claimant's status as an employee and to join any potentially responsible employers or insurers, just as it would have had if it had been processing a claim against its own insured. ORS 656.054(1) . In disregard of that obligation and without any investigation, it accepted the claim against [the alleged employer] and advised claimant that he did not need to pursue his claims or his hearing requests against the other potentially responsible entities. Having done that, SAIF may not deny the previously accepted claim on the basis of a lack of coverage." (108 Or App at 658).

Here, we do not believe that the facts provide a compelling reason to make an exception, such as the court found in Garcia, to the rule that if there is no coverage, there is no basis for payment. First, a denial of coverage in the present case would not deprive a subject worker of benefits that "no one disputes arose out of his employment." Rather, it is the law of the case that claimant was an "independent contractor" rather than a subject worker when he allegedly sustained the injury in question. Thus, a subject worker's right to compensation is not here at risk. Rather, as an independent contractor, claimant stands to gain a windfall in workers' compensation benefits should we hold that SAIF is bound to its acceptance.

Furthermore, we do not find it unreasonable for SAIF to have accepted the claim while a request for hearing filed by the alleged noncomplying employer was pending. Under the circumstances, SAIF could reasonably conclude that should claimant be determined to have been an independent contractor at the time of injury, SAIF would have no further duty or authority to process the claim in the absence of both a subject worker and a subject employer who was noncomplying. Finally, we agree with the Referee that "claimant may have relied on the stipulation, in the sense that he became accustomed to SAIF paying the bills and other benefits of workers' compensation," but such reliance was not to his detriment because he had no right to further payment of the compensation.

Accordingly, we agree with the Referee that SAIF is not bound by its stipulated acceptance of claimant's "new injury" claim. Therefore, United, as the only carrier against whom claimant had an accepted injury, remains responsible for the compensable medical services and disability involving the condition. Ricardo Vasquez, supra.

ORDER

The Referee's order dated February 1, 1991 is affirmed.

In the Matter of the Compensation of
MARVIN LANE, Claimant
WCB Case No. C2-01534
ORDER ON RECONSIDERATION APPROVING CLAIM DISPOSITION AGREEMENT
Lawrence Castle, Claimant Attorney
Scheminske & Lyons, Defense Attorney

On July 15, 1992, we disapproved the parties' proposed Claim Disposition Agreement (CDA). In reaching our conclusion, we reasoned that the consideration for the CDA could not be determined because no third party settlement or judgment had been achieved. See Kenneth Hoag, 43 Van Natta 991 (1991).

The parties have jointly requested reconsideration. Submitting an affidavit from the carrier's counsel attesting to the facts presented in the reconsideration motion, the parties represent that a third party settlement has been achieved.

In light of such circumstances, we withdraw our July 15, 1992 order. Inasmuch as a third party settlement has been reached, the concerns expressed in our prior order are no longer applicable. Since it has been more than 30 days since our receipt of the parties' CDA and claimant has not exercised his right to seek disapproval of the agreement, we proceed with our review of the disposition.

The agreement, with the inclusion of the parties' joint motion for reconsideration, is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1); OAR 436-60-145. We do not find any statutory basis for disapproving the agreement. See ORS 656.236(1). Accordingly, as supplemented by the parties' motion for reconsideration, we approve the CDA.

IT IS SO ORDERED.

In the Matter of the Compensation of
HAROLD R. BORRON, Claimant
WCB Case Nos. 91-04955, 91-08277 & 91-09296
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys
John E. Snarskis, Defense Attorney
Alan Ludwick (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Howell's order that: (1) upheld Travelers' denials to the extent that they denied responsibility for claimant's right knee condition; (2) set aside Industrial Indemnity's denial and disclaimer of responsibility for the same right knee condition; and (3) declined to assess penalties and related attorney fees against both insurers. On review, the issues are compensability, responsibility and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We adopt the conclusions and reasoning concerning the compensability and responsibility issues as set forth in the Referee's order.

Penalties

The Referee concluded, and we agree, that Travelers' denial of compensability was unreasonable because there was no evidence that claimant's right knee condition was not work-related. Travelers' denial prevented issuance of a ".307" order and placed in question claimant's right to compensation. In spite of finding the denial unreasonable, the Referee declined to assess a penalty reasoning that under Eastmoreland Hospital v. Reeves, 94 Or App 698 (1989) medical services could not serve as the basis for a penalty.

Subsequent to the Referee's order, we held that a penalty for an unreasonable denial may be based on all compensation due at the time of hearing, including medical services. Kim S. Jeffries, 44 Van Natta 419 (1992). We reasoned that because the denial is set aside, all expenses incurred by claimant for medical services and all time loss become amounts "then due" at the time of the hearing. Id. Accordingly, an amount equal to 25 percent of any compensation due at the time of hearing may be assessed against Travelers for its unreasonable denial pursuant to ORS 656.262(10).

However, Travelers argues that it reasonably feared that under the new responsibility statute, ORS 656.308(1), a concession by the last insurer that the claim was compensable as to some employer, might operate as, or constitute, a concession by the last insurer of its responsibility for the claim. Therefore, Travelers asserts that as a tactical matter, it was not unreasonable for it to deny compensability as well as responsibility, even if there was no doubt that the claim was compensable as to one of the subject Oregon employers in the case. We disagree.

ORS 656.308(1) states:

> "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 by the subsequent employer."

Here, claimant submitted a claim in 1991 alleging that he sustained a new compensable injury on January 25, 1991 while working for Travelers' insured. We find nothing in the statute which could have reasonably been interpreted to preclude Travelers from denying responsibility only, and asserting as its reason for doing so, that claimant did not sustain any "new compensable injury" in 1991 to shift responsibility from Industrial Indemnity to Travelers. In fact, whether claimant sustained a "new compensable injury" in January 1991 was the question of ultimate fact presented in the present case. By denying compensability of the claim, Travelers effectively asserted that claimant's disability and need for treatment arose from some non-work related exposures. The record contains no evidence (medical or otherwise) to support that assertion by Travelers. Therefore, notwithstanding Travelers' tactical considerations, its compensability denial was unreasonable.

Furthermore, even if the statute were properly interpreted as Travelers had feared, its compensability denial would still have been unreasonable. Where a claim is clearly work related, a pre-hearing concession that the claim is compensable as against some employer is the appropriate substitute for a finding to that effect after a hearing. Assuming a finding of compensability as against some employer (or pre-hearing concession of that fact) would shift responsibility to the last carrier (as we understand Travelers to have feared), under such circumstances, that carrier would act reasonably only by accepting the claim before hearing if it has no reason to doubt compensability. That carrier would not act reasonably by requiring a hearing on compensability when compensability is not in doubt.

In any event, Travelers' concerns about how ORS 656.308(1) might be interpreted were not well founded. Indeed, well before the hearing in this case, we interpreted 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 it can establish that claimant sustained an actual, independent compensable injury during the subsequent work exposure. Ricardo Vasquez, 43 Van Natta 1678 (1991). That was the issue here.

For Travelers' unreasonable compensability denial, a penalty will be assessed equal to 25 percent of all compensation due as of the hearing, including medical services. Kim S. Jeffries, supra.

ORDER

The Referee's order dated October 2, 1991 is reversed in part and affirmed in part. That portion of the order which declined to award claimant a penalty for Travelers' unreasonable compensability denial is reversed. Claimant is awarded a penalty equal to 25 percent of all compensation, including medical services, owing at the time of the hearing, payable by Travelers. Claimant's attorney shall receive one-half of the penalty in lieu of an attorney fee. ORS 656.262(10)(a). The remainder of the order is affirmed.

In the Matter of the Compensation of
RANDY G. FISHER, Claimant
WCB Case No. 91-04114
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation, on behalf of the noncomplying employer, requests review of that portion of Referee Crumme's order that directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree. Claimant cross-requests review of that portion of the order that affirmed a Reconsideration Order's award of 11 percent (5.28 degrees) scheduled permanent disability for a left thumb injury, whereas a Notice of Closure had awarded 18 percent (8.64 degrees). On review, the issues are extent and rate of scheduled permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

Claimant has lost 20 degrees of interphalangeal (IP) joint range of motion, due to his work injury.

CONCLUSIONS OF LAW AND OPINION

Extent of permanent disability

We adopt those portions of the Referee's "Ultimate Findings of Fact and Conclusions of Law" entitled "II. "Extent of Scheduled Permanent Partial Disability," except for the sixth through eighth paragraphs on page five, with the following supplementation.

Claimant argues that the Referee should have "remanded" the case to the Director for completion of the reconsideration process. Specifically, claimant contends that the Director should have appointed a medical arbiter as arguably required by amended ORS 656.268(7) and, had that been done, claimant contends that, under ORS 656.726(3)(f)(C), temporary rules would have been adopted amending the standards, to accommodate claimant's impairment. We disagree.

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. We disagree with the Referee's application of amended ORS 656.268(7) and 656.726.

Section 54 of the 1990 Act sets out the applicability provisions of the amendments. In the present case, claimant requested a hearing after May 1, 1990 and the hearing was convened after July 1, 1990. For this reason, and because application of 1990 law will not produce an absurd result, most of

the amendments are applicable. Or Laws 1990 (Special Session), ch. 2, §54; See Ida M. Walker, 43 Van Natta 1402 (1991).

However, Section 54(3) of the Act provides, in relevant part:

> "Amendments by this 1990 Act to . . . ORS 656.268(4), (5), (6),(7) and (8). . . and 656.726 shall apply to all claims which become medically stationary after July 1, 1990.

Claimant became medically stationary on November 16, 1988. (Ex. 11).[1] Therefore, pursuant to Section 54(3), supra, amended ORS 656.268(7) and 656.726 do not apply and the procedures sought by claimant are not available to him.

Claimant also argues that he is entitled to an increased permanent disability award. In this regard, claimant contends that the standards contained in WCD Admin. Order 1-1989 control the evaluation of his permanent disability and that the temporary rules found in WCD Admin. Orders 15-1990 & 20-1990, adopted effective October 1, 1990 and November 20, 1990 respectively, are inapplicable because they are invalid. We need not decide whether the temporary rules are valid, because even if they are applicable to this claim, claimant's disability award is the same under WCD Admin. Order 1-1989, with or without temporary WCD Admin. Orders 15 & 20.

SAIF contends that the permanent standards subsequent to the disputed temporary rules apply here. See WCD Admin. Order 2-1991. We disagree. Under former OAR 436-35-003(1), the rules in WCD Admin. Order 2-1991 "shall be applied to all claims closed on or after April 1, 1991, for workers medically stationary after July 1, 1990." Because claimant became medically stationary on November 16, 1988 and his claim was closed on October 26, 1990, the later standards do not apply.

Claimant has lost 20 degrees of interphalangeal (IP) joint range of motion, due to his work injury. (Ex.8B). Under former OAR 436-35-050(1), claimant is entitled to an 11 percent rating for this loss. See former OAR 436-35-010(3), contained in WCD Admin. Order 1-1989. Therefore, we affirm the Referee's order which affirmed the Order on Reconsideration.

Rate of scheduled permanent disability

The Referee concluded that claimant's award of scheduled permanent disability should be paid at the rate of $305 per degree. The Referee relied on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), in which we held that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. Subsequent to the Referee's order, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (July 8, 1992).

In this case, claimant was injured before May 1, 1990. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury. ORS 656.202(2); former ORS 656.214(2).

ORDER

The Referee's order dated August 16, 1991, as reconsidered November 5, 1991, is reversed in part and affirmed in part. Those portions of the order that directed the SAIF Corporation to pay claimant's scheduled disability award at the rate of $305 per degree and awarded an attorney fee payable out of the increased compensation are reversed. The remainder of the order is affirmed.

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[1] Claimant does not dispute the November 16, 1988 medically stationary date established by the June 25, 1991 Order on Reconsideration.

In the Matter of the Compensation of
JACK L. ROACH, Claimant
WCB Case No. 91-08554
ORDER OF ABATEMENT
Hollis Ransom, Claimant Attorney
Daryll E. Klein, Defense Attorney

Claimant requests reconsideration of our July 23, 1992 Order on Review. In that order, we found that the preponderance of the evidence established that claimant's physical capacity is within the medium-light category, which results in an adaptability value of 3.5. In his request for reconsideration, claimant asserts that the parties stipulated at hearing that his return to work restrictions were in the light to sedentary category. Based on this assertion, claimant argues that his adaptability value should be 8.

In order to fully consider claimant's motion, we withdraw our July 23, 1992 order. The insurer is granted an opportunity to respond by submitting a response within 10 days of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
TERRY L. SCHALLER, Claimant
WCB Case No. 91-07876
ORDER ON REVIEW
Daniel Snyder, Claimant Attorney
Susan D. Ebner (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of those portions of Referee Peterson's order that: (1) directed it to pay temporary disability compensation for the period from July 4, 1991 through July 22, 1991; and (2) assessed a penalty and separate attorney fee for its allegedly unreasonable resistance to payment of that compensation. SAIF requests remand for consideration of documentary evidence offered to establish its prior payment of temporary disability compensation for the above-mentioned time period. On review, the issues are temporary disability, remand and penalties and attorney fees. We deny the motion to remand, reverse in part and affirm in part.

FINDINGS OF FACT

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

We do not find that SAIF failed to pay temporary disability compensation for the period from July 4, 1991 through July 22, 1991.

CONCLUSIONS OF LAW AND OPINION

The Referee found that SAIF failed to pay temporary disability compensation for the period from July 4 through July 22, 1991, ordered payment of compensation for that period, and assessed a penalty and separate attorney fee based on SAIF's allegedly unreasonable resistance to the payment of that compensation. Because the Referee's finding regarding SAIF's nonpayment is not supported by evidence in the record, we reverse.

At the outset of the hearing, claimant's attorney listed nonpayment of temporary disability compensation for periods after July 3, 1991 as an issue. (Tr. 3-5). As we have stated, the Referee found that temporary disability compensation was not paid after July 3, 1991. However, the only evidence arguably relevant to the nonpayment issue is Exhibit 16, SAIF's temporary disability payment summary

dated July 11, 1991, and claimant's testimony concerning that document. Claimant's counsel noted that the payment summary indicated that claimant had "only been paid a total of $967.75 from May 24th through July 3, 1991." (Tr. 25; see Ex. 16). Claimant responded, "Sounds about right." (Id). However, neither claimant's testimony nor the July ll, 1991 payment summary sheet indicate whether payments were made for periods after July 3, 1991. The summary listed only payments sent before July 10, 1991, for periods ending July 3, 1991, and did not purport to cover any subsequent period. Compensation for periods beginning July 4, 1991 was not due until 14 days thereafter, i.e., on July 18 a week after the July 11 summary. See former ORS 656.262(4). Therefore, we conclude that Exhibit l6 and claimant's testimony about that exhibit do not establish that SAIF failed to pay temporary disability compensation for periods after July 3, 1991.

Our review must be based on the record developed by the Referee. Former ORS 656.295(3) & (5). In this case, our review reveals no evidence relevant to the purported nonpayment of temporary disability compensation for periods after July 3, 1991. Claimant's counsel is not a witness in this case. His assertion that SAIF failed to pay the disputed temporary disability compensation was not evidence which shifted the burden of going forward on this issue to SAIF.

We acknowledge that an injured worker is not required to prove a negative. However, he or she must raise the nonpayment issue with evidence of some kind. Here, because the Referee's finding regarding SAIF's nonpayment of the disputed compensation is not based on record evidence, it is in error. Consequently, the order to pay compensation and the assessment of penalties and attorney fees, which stem from the unsupported finding of nonpayment must be reversed. Moreover, because the nonpayment issue was not adequately raised by the evidence, SAIF was not required to defend by proving payment. Accordingly, SAIF's request for remand for the purpose of proving payment is denied as it is moot by virtue of our order.

ORDER

The Referee's order dated September 12, 1991 is reversed in part and affirmed in part. That portion of the order that directed SAIF to pay temporary disability compensation for the period from July 4, 1991 through July 22, 1991 is reversed. Those portions of the order that assessed a penalty and separate attorney fee based on SAIF's alleged unreasonable resistance to the payment of that compensation are reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
RAYMOND J. SEEBACH, Claimant
WCB Case No. 91-02703
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of Referee Galton's order which: (1) directed the insurer to pay claimant temporary total disability benefits from March 1, 1990 through September 17, 1990; (2) awarded penalties and attorney fees for an allegedly unreasonable resistance to the payment of compensation; (3) awarded an assessed attorney fee for prevailing on the temporary disability issue; and (4) awarded an additional assessed attorney fee for prevailing against the insurer's cross-request for hearing. On review, the issues are temporary disability benefits, 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.

A December 11, 1991 Order on Review reversed that portion of Referee Peterson's February 1, 1991 Opinion and Order that directed the insurer to pay claimant's temporary disability compensation

from March 1, 1990 through August 27, 1990 pending the insurer's request for Board review of an earlier referee's order. Raymond J. Seebach, 43 Van Natta 2687 (1991). The Order on Review affirmed Referee Peterson's order insofar as it directed the insurer to pay temporary disability compensation from August 28, 1990 through September 17, 1990. The order further affirmed Referee Peterson's order to the extent that the insurer was assessed a 25-percent penalty based upon temporary disability compensation due from August 28, 1990 through September 17, 1990, for insurer's unreasonable failure to pay the benefits from an earlier referee's order.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability Benefits

Referee Galton directed the insurer to pay temporary disability benefits from March 1, 1990 through September 17, 1990. We disagree in part.

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 decision meets the aforementioned standard, we take administrative notice of it.

Referee Peterson concluded that the insurer was not entitled to stay payment of compensation pending its appeal of Referee Schultz's order and therefore directed the insurer to pay temporary disability compensation from March 1, 1990 through September 17, 1990 as well as an attendant penalty. Thereafter, the insurer sought Board review of Referee Peterson's order. Claimant then sought a hearing before the present Referee (Galton) regarding the insurer's failure to comply with Referee's Peterson's order.

Subsequent to Referee Galton's order, we reversed that portion of Referee Peterson's order that directed the insurer to pay temporary disability benefits from March 1, 1990 through August 27, 1990. Raymond J. Seebach, supra. Consequently, the law of the case is that the insurer was entitled to stay compensation from March 1, 1990 through August 27, 1990. Accordingly, that portion of Referee's Peterson's order which held to the contrary is now null and void. See Dean L. Watkins, 44 Van Natta 1006 (1992); Robert W. Bright, Jr., 44 Van Natta 917 (1992). Therefore, Referee Galton's conclusion that the insurer must pay compensation in accordance with Referee Peterson's order is likewise contrary to the law of the case. [1]

We note, however, that our prior order did affirm that portion of Referee Peterson's order that directed the insurer to pay temporary disability compensation from August 28, 1990 through September 17, 1990. Therefore, Referee Galton's order is affirmed to the extent that it directed the insurer to pay temporary disability compensation for that time period.

Penalties

Referee Galton assessed a 25 percent penalty based on unpaid temporary disability compensation from March 1, 1990 through September 17, 1990. We disagree.

As noted above, the insurer was entitled to stay temporary disability compensation from March 1, 1990 through August 27, 1990. Moreover, we reversed that portion of Referee's Peterson's order which had previously assessed a penalty for failure to pay temporary disability compensation for those dates. Inasmuch as the insurer was entitled to stay payment of temporary disability benefits from March 1, 1990 through August 27, 1990, it follows that its failure to pay these benefits was not unreasonable. Accordingly, we reverse that portion of Referee Galton's order that assessed a penalty for failure to pay temporary disability compensation from March 1, 1990 through August 27, 1990.

However, we have previously found, and the insurer has conceded, that its failure to pay

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[1] Although a signatory to the present order, Member Gunn directs the parties' attention to his dissenting opinion in Raymond J. Seebach, 43 Van Natta 2687 (1991).

temporary disability benefits from August 28, 1990 through September 17, 1990 in compliance with Referee Schultz's order is unreasonable. Therefore, we affirm the Referee's award of a penalty for failure to pay temporary disability benefits from August 28, 1990 through September 17, 1990 in compliance with Referee Peterson's order.

Attorney Fees

In addition to the penalty, Referee Galton also awarded claimant's counsel an assessed attorney fee of $2,000 under ORS 656.382(1) for the insurer's failure to comply with Referee Peterson's order. We disagree.

Subsequent to Referee Galton's order, we held that when the factual basis asserted in support of an attorney fee for unreasonable resistance to the payment of compensation under ORS 656.382(1) is identical to the factual basis for the assessment of a penalty under ORS 656.262(10)(a), the assessment of an attorney fee award pursuant to ORS 656.382(1) would contravene the legislative intent expressed in ORS 656.262(10)(a) that a claimant's attorney would receive one-half of the penalty, "in lieu of an attorney fee." Nicolasa Martinez, 43 Van Natta 1638 (1991).

Here, we found that the insurer's failure to pay temporary disability compensation from March 1, 1990 through August 27, 1990 was not unreasonable. Therefore, the only basis for a penalty is the insurer's failure to pay temporary disability benefits from August 28, 1990 through September 17, 1990. We have herein affirmed Referee Galton's assessment of a penalty, one-half of which is payable to claimant's counsel, for the insurer's failure to pay temporary disability benefits from August 28, 1999 through September 17, 1990. The factual basis for an attorney fee under ORS 656.382(1) is identical to the factual basis on which the penalty was assessed. Consequently, claimant's counsel is not entitled to an additional assessed attorney fee for the insurer's failure to pay compensation.

Finally, the Referee also awarded claimant's counsel a $100 assessed attorney fee for prevailing against the insurer's cross-request for hearing concerning an offset issue. We disagree. An offset does not reduce compensation within the meaning of ORS 656.382(2). See Christine L. Davis, 42 Van Natta 397, 398 (1990); see also Strazi v. SAIF, 109 Or App 105 (1991). Therefore, claimant is not entitled to an assessed fee in this matter.

ORDER

The Referee's order dated July 3, 1991 is reversed in part and affirmed in part. The Referee's order is reversed to the extent that it directed the insurer to pay temporary disability compensation from March 1, 1990 through August 27, 1990. The Referee's order is also reversed to the extent that it awarded a penalty for the insurer's failure to pay temporary disability benefits from March 1, 1990 through August 27, 1990. The Referee's awards of a $2,000 assessed attorney fee and a $100 assessed attorney fee are reversed. The Referee's order is affirmed to the extent that it directed the insurer to pay temporary disability compensation from August 28, 1990 through September 17, 1990. The Referee's award of a penalty (to be shared equally by claimant and his counsel) for failure to pay temporary disability compensation from August 28, 1990 through September 17, 1990 is also affirmed.

In the Matter of the Complying Status of
SUNSET SIDING CONSTRUCTION, INC., Noncomplying Employer
WCB Case No. 91-00509
ORDER ON RECONSIDERATION
Christopher Rounds, Attorney
Breathouwer, et al., Attorneys
Saif Legal Department, Attorney
Bottini, et al., Attorneys
Dunn, et al., Attorneys

Sunset Siding Construction has requested reconsideration of our July 15, 1992 Order of Dismissal which dismissed requests for review filed by claimant, Masterpiece Construction, and Sunset. Submitting an affidavit describing its counsel's services, Sunset seeks an attorney fee award pursuant to ORS 656.740(5). The request for attorney fees is denied.

If a person against whom an order is issued pursuant to ORS 656.740 prevails at hearing or on appeal, the person is entitled to reasonable attorney fees to be paid by the Director. ORS 656.740(5).

Here, Sunset Siding did not prevail on appeal against a Director's order issued in accordance with ORS 656.740. Rather, Sunset prevailed at hearing concerning its objection to the Director's order finding Sunset to be a noncomplying employer. For Sunset's counsel's efforts at hearing, the Referee awarded Sunset a $2,750 attorney fee to be paid by the Director pursuant to ORS 656.740(5).

Had Sunset been unsuccessful at hearing and eventually successful on appeal against the Director's noncompliance order, Sunset would be entitled to an attorney fee award for services at both the hearings and appellate levels. However, because Sunset prevailed at hearing, its attorney fee award pursuant to ORS 656.740(5) extends only to that level.

Furthermore, we have dismissed the requests for Board review of the Referee's order (which parenthetically included a request from Sunset) on the basis that we lack jurisdiction to consider the appeals. Since we are not the appropriate forum to address the parties' appeals, it follows that we are similarly without authority to award attorney fees for such appeals.

Based on the aforementioned reasoning, we deny Sunset's request for an attorney fee award for services on appeal of the Referee's order.

Accordingly, we withdraw our July 15, 1992 order. On reconsideration, as supplemented herein, we republish our July 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
MARLENE J. ANDRE, Claimant
WCB Case No. 91-04449
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Neal's order that dismissed claimant's hearing request for lack of subject matter jurisdiction. On review, the issue is jurisdiction.

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

jurisdiction over palliative care issues rests with the Director. Rexi L. Nicholson, 44 Van Natta 1546 (1992).[1]

Here, claimant argues that she is entitled to the requested palliative care pursuant to OAR 436-10-041. See WCD Admin Order 32-1990; OAR 436-10-003(5). OAR 436-10-041 states that "[i]f the attending physician does not receive written notice disapproving the care from the insurer within 30 days as set forth in section (3) of this rule, the request for palliative care shall be approved." Here, the SAIF Corporation never responded to the attending physician's palliative care request. However, because issues regarding palliative care are within the exclusive jurisdiction of the Director, it is the Director who must approve the palliative care request under these circumstances.

ORDER

The Referee's order dated July 18, 1991 is affirmed.

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[1] Although a signatory to the present order, Board Member Gunn directs the parties' attention to his dissenting opinion in Rexi L. Nicholson, supra.

In the Matter of the Compensation of
EDWIN J. BRUNES, Claimant
WCB Case No. 91-05773
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Davis' order that: (1) upheld the insurer's denial of his claim for his low back injury; and (2) declined to assess a penalty and related attorney fee for an allegedly unreasonable denial. In its brief, the insurer contends that claimant has "waived" the penalty issue. 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

The Referee concluded that claimant had not established that work was the major cause of his current low back condition. We agree with the Referee that claimant has failed to meet his burden of proof, however, we apply the following analysis.

Subsequent to the Referee's order, we issued Bahman M. Nazari, 43 Van Natta 2368 (1991), in which we held that ORS 656.006(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. Accordingly, in order to establish an initial compensable injury, claimant only has to prove that work was a material contributing cause of his condition. See also Mark N. Wiedle, 43 Van Natta 855 (1991).

Nonetheless, even under the material contributing cause standard, we agree with the Referee's conclusion that claimant has failed to establish causation. Although claimant contends that he sustained an industrial injury on February 4, 1991, we do not find that the record supports such a claim.

Here, claimant had suffered from previous back and neck injuries and had undergone chiropractic treatment for those conditions. Moreover, two weeks prior to the incident, claimant had

developed a severe cough which resulted in a sore back. Finally, although claimant argues that his low back condition resulted from his use of a chain saw at work on February 4, he also informed his treating chiropractor that coughing had triggered the onset of his low back pain. In addition, on the evening of February 4, claimant told his employers that his back pain had been triggered by coughing. Furthermore, he did not relate that he had experienced back pain following the use of the chain saw.

Under the circumstances, we agree with the insurer's contention that claimant has failed to show that, as a result of an incident at work, he developed a sudden onset of pain over a discrete period. See Taylor v. Multnomah County School Dist. No. 1, 109 Or App 499 (1991); Wausau Insurance Company v. Huhnholz, 85 Or App 199 (1987). Accordingly, we conclude that claimant has not met his burden to prove that he suffered an injury on February 4, 1991 which was a material contributing cause of his disability or need for medical services. We, therefore, affirm the Referee on the issue of compensability.

Penalties and attorney fees

We adopt the Referee's Conclusions of Law and Opinion on the penalty issue.

ORDER

The Referee's order dated October 18, 1991 is affirmed.

August 7, 1992 Cite as 44 Van Natta 1589 (1992)

In the Matter of the Compensation of
CONNIE R. DIAS, Claimant
WCB Case No. 91-03860
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

Claimant requests review of Referee Neal's order that found that the Hearings Division was without jurisdiction over her medical services claim. On review, the issues are jurisdiction and medical services. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The Referee concluded that she did not have jurisdiction over claimant's hearing request because a resolution proceeding was provided pursuant to ORS 656.704 and 656.327 and the Director had original jurisdiction over the medical services issue. The Referee also concluded that because this matter involved a fee dispute issue, and claimant's treating chiropractor did not timely apply for relief from the Department, the Hearings Division did not have jurisdiction over the issue raised by claimant.

At the outset, we note that the insurer contends that the 1990 amendments to the Workers' Compensation Act apply to this case. However, we have previously held that we will not apply the amended law retroactively in cases in which such application would produce an absurd result or would unreasonably prejudice claimant. See Ida M. Walker, 43 Van Natta 1402 (1991) (amended ORS 656.245(1) not applied retroactively to require an attending physician to request approval for palliative care before such services are rendered, where an application of the new law would disallow services claimant received before the effective date of the Act, unless her physician could somehow comply with a law not yet in existence).

Here, the treatment at issue was provided by Dr. Segur, claimant's treating chiropractor, and had been entirely provided by 1988. In December 1989, Dr. Segur informed the insurer that claimant's bills for treatment, beginning in October 1987 and continuing through October 1988, had never been paid. Claimant's original hearing request on the insurer's refusal to pay Dr. Segur was filed in December 1989.

At hearing, the insurer argued that claimant's care was at a palliative care level and, because claimant was not able to continue treating with Dr. Segur, the issue was "whether he had gone through the hoops to get additional care approved by the carrier." We conclude that if the insurer is arguing that claimant's palliative care is not compensable under the new law, application of the 1990 amendments would produce an absurd result, considering that all of claimant's treatment was provided before the 1990 amendments became effective. To require Dr. Segur to request approval for palliative care (i.e., to require compliance with a law not yet in effect) not only produces an absurd result, but also constitutes unreasonable prejudice to claimant. See Ida M. Walker, supra.

The insurer also argues that this matter involves a fee dispute and, therefore, the Director has jurisdiction, rather than the Board. We disagree.

The only evidence to support the insurer's argument is its contention and a letter from the Department concluding that it "appears" that Dr. Segur's complaint involves a fee dispute resolution request. (Ex. 7-1.) However, we are not persuaded that this matter involves such a dispute.

Here, Dr. Segur has informed both the insurer and claimant's attorney that his bills have not been paid. Both claimant's counsel and Dr. Segur have requested payment from the insurer. (Ex. 3, 6). Claimant's initial request for hearing stated one of the medical services issues as "failure to timely reimburse Dr. Segur." (Ex. 3A). Moreover, at hearing, the insurer argued that the issue was whether Dr. Segur had "gone through the hoops to get additional treatment approved by the carrier, and we think that boils down to a fee dispute."

We conclude that this matter does not involve a dispute over a fee for medical services. There is no evidence, for example, that there were errors contained in Dr. Segur's bills, that the amount of the fees was excessive or that the insurer had been billed for services not provided. Finally, the insurer neither accepted nor denied the claim within 60 days of notice or knowledge of the medical bill or claim.

Under the circumstances, we agree with claimant that this matter actually consists of a "de facto" denial of medical services. Therefore, we conclude that we have jurisdiction to address the merits of claimant's medical services claim. We also find the record to be adequately developed for purposes of review.

Medical services

At hearing and on review, the insurer has maintained that the causal relationship between Dr. Segur's treatment and claimant's condition has not been contested. Accordingly, we determine whether claimant's medical treatment is reasonable and necessary.

A claimant is entitled to all reasonable and necessary curative or palliative medical treatment required for recovery from a compensable injury or for relief of pain. Former ORS 656.245(1); Wetzel v. Goodwin Bros., 50 or App 101 (1981). Here, Dr. Segur reported that claimant's chiropractic treatment was recommended for palliative therapy and that, due to unpredictable periodic episodes of acute exacerbation and deterioration of her condition, claimant would occasionally need treatment in excess of the guidelines. (Ex. 2). At hearing, claimant testified that Dr. Segur's treatment was of benefit to her and assisted in reduction of her pain and increased her movement. (Tr. 18). Moreover, there is no evidence to the contrary.

We conclude that claimant has established that her treatment with Dr. Segur was reasonable and necessary. Accordingly, claimant's request for hearing is reinstated and the insurer's "de facto" denial of such treatment is set aside.

Penalties and attorney fees

Claimant contends that a penalty and attorney fee should be assessed for the insurer's unreasonable resistance to the payment of compensation. However, we conclude that because Dr. Segur initially reported this matter to the Director and the parties were informed that the matter apparently involved a "fee dispute," it was not unreasonable for the insurer to believe that the Director had original jurisdiction over this matter. Therefore, we decline to assess a penalty and attorney fee.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable 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 considered the time devoted to the issue (as represented by the record and claimant's appellate brief), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated July 2, 1991 is reversed. Claimant's request for hearing is reinstated. The insurer's "de facto" denial is set aside and the medical services claim is remanded to the insurer for acceptance and processing according to law. For services at hearing and on review, claimant's counsel is entitled to an attorney fee of $2,000, payable by the insurer.

In the Matter of the Compensation of
CHUCK W. CHOWNING, Claimant
WCB Case Nos. 90-00167 & 90-04239
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Cummins, et al., Defense Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Moller.

The SAIF Corporation (on behalf of Mitts Logging Company) requests review of Referee McWilliams' order that: (1) set aside its denial of claimant's aggravation claim for his cervical, lumbar and right arm conditions; and (2) upheld SAIF's denial (on behalf of Burt Logging Company) of claimant's "new injury" 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 following supplementation.

In September 1989, claimant filed a request for hearing on the issues of SAIF's failure to accept or deny his aggravation claim, interim compensation, and penalties and attorney fees. The request for hearing was assigned WCB Case No. 89-18464.

On December 15, 1989, SAIF denied claimant's aggravation claim.

On January 9, 1990, the parties went to hearing on WCB Case No. 89-18464. At hearing, the parties agreed that all matters had been settled with the exception of an attorney fee.

On February 22, 1990, claimant requested a hearing from the December 1989 aggravation denial. The case was assigned WCB No. 90-00167.

On February 23, 1990, the Referee's Opinion and Order issued in WCB No. 89-18464, and awarded claimant's counsel an attorney fee.

On February 26, 1990, the Referee signed a Stipulation and Order concerning WCB Case No. 89-18464. The stipulation provided that claimant's request for hearing raised issues including late payment of temporary disability. The stipulation provided for a penalty and dismissed claimant's request for hearing. Finally, the stipulation provided that the parties agreed to settle all issues "raised or raisable at this time."

CONCLUSIONS OF LAW AND OPINION

We note preliminarily that, because a hearing in this matter was convened prior to July 1, 1990, we analyze this case under the law in effect prior to its amendment by the 1990 Special Session. See Or Laws 1990 (Special Session), ch 2, § 54.

Compensability

The Referee found that claimant's aggravation claim was compensable. However, the Referee concluded that claimant was required to establish an aggravation from the time of the February 23, 1990 Opinion and Order, as claimant could have challenged the aggravation denial at that time, and his failure to do so precluded him from establishing an aggravation before that date.

On review, SAIF/Mitts contends that although the Referee used an incorrect timeframe in her subsequent analysis, claim preclusion does bar claimant from establishing an aggravation prior to the date of the February 23, 1990 order. We disagree.

The doctrine of res judicata precludes relitigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, 50, modified 305 Or 468 (1988). A claim is a transaction or series of transactions arising from the same set of operative facts. Carr v. Allied Plating Co., 81 Or App 306 (1986). Under the res judicata doctrine of "claim preclusion," litigation of a claim or cause of action to final judgment precludes a subsequent action between the same parties on the same claim or any part thereof. Carr v. Allied Plating, supra at 309; Restatement (Second) of Judgments, Sections 17-19, 24 (1982). Under the doctrine of "issue preclusion," if a claim is litigated to final judgment, the decision on a particular issue or determinative fact is conclusive in a later or different action between the same parties if the determination was essential to the judgment. North Clackamas School District, supra at 53. A Referee's order approving a stipulation and dismissing a claimant's request for hearing is a "judgment" within the meaning of the above rules. See ORS 656.289(4); Proctor v. SAIF, 68 Or App 333 (1984).

Here, we conclude that the subject of both the Referee's Opinion and Order of February 23, 1990 and the February 26, 1990 Stipulation and Order consisted of interim compensation and penalties and attorney fees for unreasonable claims processing. The issue of compensability of the aggravation claim was not litigated. Consequently, that issue was not precluded under the doctrine of issue preclusion.

We next turn to claim preclusion by the stipulation. SAIF contends that, because the stipulation contained the language that all issues "raised or raisable" were settled by the February 1990 stipulation and order, claimant also settled the issue of aggravation. We disagree.

Claimant waived his right to the issue of compensability of aggravation only if he intended to waive that right when he signed the stipulation. See David M. Marvin, 42 Van Natta 1778 (1990). As noted above, the claim which was the subject of the stipulation was based upon SAIF's failure to accept or deny the aggravation claim, in addition to claimant's entitlement to interim compensation. The stipulation dismissed claimant's request for hearing in that case, WCB No. 89-18464, but failed to mention the issue of aggravation or the subsequent request for hearing in WCB No. 90-00167. Accordingly, we are unable to find an intentional, knowing waiver of the claim for aggravation. Furthermore, claimant's claim for penalties and attorney fees based upon unreasonable claims processing and interim compensation benefits did not involve the same set of operative facts as the claim for aggravation. Accordingly, we conclude that the stipulation does not bar claimant's current claim for aggravation.

SAIF next contends that, even if claim preclusion does not bar claimant's aggravation claim, he is unable to show a worsening of his compensable condition. SAIF argues that the Referee erred by relying upon the opinions of Dr. Kitchell and Dr. Matteri, because both doctors based their opinions upon an unreliable history.

To establish a compensable aggravation claim, claimant must prove a worsened condition resulting from the compsenable injury. The condition must have worsened since the last award or arrangement of compensation. ORS 656.273(1); Smith v. SAIF, 302 Or 396 (1986). A "worsened condition" means increased symptoms, or a pathological change, resulting in diminished earning capacity. Perry v. SAIF, 307 Or 654, on remand 99 Or App 52 (1989). Additionally, if the last arrangement of compensation contemplated future periods of increased symptoms accompanied by diminished earning capacity, claimant must prove that his diminished earning capacity exceeded that contemplated. Gwynn v. SAIF, 304 Or 345 (1987). In the present case, claimant must prove that his condition has worsened since the October 26, 1988 Determination Order which awarded 4 percent unscheduled permanent disability.

We agree with the Referee's conclusion that the reports of Drs. Matteri and Kitchel establish that claimant's condition had worsened since the last arrangement of compensation. Accordingly, we adopt her conclusions on that issue. Furthermore, we conclude that claimant's "dead arm" and increased back pain establish that claimant's diminished earning capacity has exceeded that of the "continued annoyance" predicted by Dr. Holbert at the time of claim closure. Therefore, we agree with the Referee that claimant has proven that his aggravation claim is compensable.

Responsibility

We adopt the Referee's conclusions on the issue of responsibility.

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 SAIF/Mitts. 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 23, 1991 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $800, payable by the SAIF Corporation, on behalf of Mitts Logging Company.

August 7, 1992 Cite as 44 Van Natta 1593 (1992)

In the Matter of the Compensation of
LESTER E. COOLIDGE, Claimant
WCB Case Nos. 91-12951, 91-08359 & 91-04356
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The Medford Corporation (Medco) requests review of Referee Brown's order that: (1) set aside its denial of claimant's occupational disease claim for a left shoulder condition; and (2) upheld the SAIF Corporation's denial of claimant's occupational disease claim for the same condition. On review, the issue is responsibility.

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

SAIF insured Medco until July 1, 1988. Since that date, Medco has been self-insured. The

Referee applied the last injurious exposure rule to determine that responsibility should be assigned to Medco in its self-insured capacity. We agree.

We have held that ORS 656.308(1) does not change the prior law regarding the initial assignment of responsibility in cases in which there has been no prior accepted occupational disease claim for the same condition. Fred A. Nutter, 44 Van Natta 854 (1992). In such cases, the last injurious exposure rule continues to operate. Fred A. Nutter, supra; Eleanor G. Castrignano, 44 Van Natta 1134 (1992). Here, there was no prior accepted claim. Accordingly, the Referee correctly applied the last injurious exposure rule to determine responsibility.

On review, Medco argues that the Referee erred in relying on Dorothy Amstutz, 41 Van Natta 2292 (1989), for the proposition that responsibility is fixed with the employer on the risk at the time of the first actual disability, rather than the employer on the risk on the date of the first medical treatment. Medco asserts that the holding in Amstutz is contrary to the court's holdings in SAIF v. Gupton, 63 Or App 270 (1983) and United Pacific v. Harris, 63 Or App 270 (1983) where the date of first medical treatment, rather than disability, appeared to have been used to determine which employment was the last potentially causal employment. Medco argues that under Harris and Gupton, the date of actual disability does not count for any more than the first instance of treatment. We disagree. Harris and Gupton are factually distinguishable from the present case and from Amstutz. In both Harris and Gupton, the court determined that the employment at the subsequent employer did not contribute to the causation or worsening of claimant's underlying condition. Consequently, in both cases, responsibility remained with the first employer instead of the second employer, even though actual disability occurred at the second employer. Here, by contrast, the evidence indicates that claimant's work at Medco (pulling on the round table) did contribute to claimant's underlying condition. Likewise, in Amstutz, employment at the second employer contributed to claimant's underlying condition.

The "onset of disability" is the triggering date for determination of which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). The onset of disability is the date upon which the claimant first becomes disabled as a result of the compensable condition or, if the claimant does not become disabled, the date upon which 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 Referee determined, and we agree, that claimant became disabled when Dr. Moline permanently restricted him from doing heavy repetitive pulling. Subsequent to this restriction, claimant was moved to another job within the mill. Because claimant did become disabled, the date of this disability and not the date of his first medical treatment is the critical date for determining the onset of disability. Id. Thus, responsibility initially rests with Medco, the carrier on the risk at the date of disability. Furthermore, responsibility remains with Medco because the record does not support a conclusion that the sole cause, or worsening, of claimant's left shoulder condition was his employment exposure while SAIF was on the risk or that it was impossible for work conditions while Medco was on the risk to have caused claimant's disability. See FMC Corporation v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified 73 Or App 223 (1985); David J. Rosenbaum, 43 Van Natta 9500 (1991). Accordingly, the Referee did not err in assigning responsibility to Medco.

Both compensability and responsibility were decided by the Referee. Therefore, by virtue of the Board's de novo review authority, compensability remained at risk on review as well. See Dilworth v. Weyerhaeuser Co., 95 Or App 85 (1989). Consequently, claimant's counsel is entitled to an assessed attorney fee for services on Board review. See Tanya L. Baker, 42 Van Natta 2818 (1990).

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, payable by Medco. 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 November 14, 1991 is affirmed. For services on Board review, claimant's counsel is awarded a reasonable fee of $800, payable by Medco.

In the Matter of the Compensation of
RONALD R. EHLY, SR., Claimant
WCB Case Nos. 91-00220 & 91-03302
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Snarskis, Yager, et al., Defense Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of Referee Michael V. Johnson's order that: (1) set aside its "back-up" denial of claimant's "new injury" claim for his low back condition; and (2) upheld Industrial Indemnity Company's denial of claimant's aggravation claim for the same condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

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

In 1979, claimant suffered a low back injury which was accepted by the employer's insurer, Industrial Indemnity. Claimant eventually received a total award of 15 percent unscheduled permanent disability for his injury.

In 1985, claimant's claim was reopened as an aggravation and he underwent surgery at L4. He subsequently returned to regular work.

In June 1990, claimant was working as a jointer operator for the same employer. Claimant jumped down from the machine he was operating and felt an immediate onset of low back pain. He treated with Dr. Herscher and filed a new injury claim with the employer. By the time of his June 1990 injury, the employer had become self-insured.

On July 24, 1990, the self-insured employer accepted claimant's injury claim for the June 1990 incident.

On July 30, 1990, claimant underwent a decompressive laminectomy.

On December 10, 1990, the employer issued a "back-up" denial of claimant's injury claim.

In January 1991, claimant filed an aggravation claim with Industrial Indemnity.

On March 18, 1991, Industrial Indemnity denied responsibility for claimant's condition.

CONCLUSIONS OF LAW AND OPINION

The Referee first analyzed claimant's claim under ORS 656.308(1) and concluded that claimant sustained a new compensable injury while working for the self-insured employer in June 1990. The Referee concluded that responsibility had shifted to the employer who became responsible for claimant's low back condition. Finally, the Referee made an alternative finding that the employer had failed to prove by clear and convincing evidence that claimant's low back claim was not compensable. We offer the following analysis.

Back-up Denial

We have previously concluded that, pursuant to amended ORS 656.262(6), a carrier may now issue a back-up denial at any time up to two years from the date of claim acceptance. Within that two-year period, a carrier need not prove fraud, misrepresentation or other illegal activity in support of its back-up denial. Anthony G. Ford, 44 Van Natta 240 (1992). Instead, the carrier must establish by clear and convincing evidence obtained after the acceptance that the claim is not compensable. Sharon J. True, 44 Van Natta 261 (1992).

Here, the employer's back-up denial was issued within two years of the date that it accepted claimant's low back injury claim. Accordingly, the employer need not prove fraud, misrepresentation or other illegal activity to support the denial. However, because claimant requested a hearing from the employer's denial, the employer is required to prove by clear and convincing evidence that the claim is not compensable. ORS 656.262(6). Therefore, the employer 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, the employer contends that claimant's condition is a continuation of his prior low back problems. The employer argues that the opinion of Dr. Campagna, claimant's treating surgeon, is not persuasive because Dr. Campagna based his opinion of a new injury upon a CT scan which presumably showed a fracture through the pedicles at L5. The employer argues that Dr. Campagna's opinion has been undermined because, during surgery, Dr. Campagna found no evidence of such a fracture. Finally, the employer argues that, if anything, claimant merely experienced increased symptoms following the June 1990 incident.

We agree with the Referee's conclusion that the employer has failed to show by clear and convincing evidence that claimant did not sustain a compensable low back injury in June 1990. Both Dr. Campagna and Dr. Hacker have opined that the June 1990 injury was the major cause of claimant's condition. Exs. 26, 34, 35. Furthermore, Dr. Campagna did not base his opinion solely upon the existence of pedicle fractures. Rather, he explained in his July 20, 1990 letter that his opinion regarding a new injury was based upon claimant's history, continued complaints and the positive diagnostic findings. Furthermore, even following the surgery and his finding that there was no evidence of pedicle fractures, Dr. Campagna continued to opine that claimant's need for surgery was due to the June 26, 1990 injury.

Finally, the only medical evidence in the record against the finding of a new injury is a concurrence letter from Dr. Gilmore, M.D. in which he opines that claimant did not sustain a new injury. However, his opinion was based solely upon his finding that the CT scan showed healing around the pedicle fractures, which led him to believe that the fractures could not have been caused by the recent June 26, 1990 injury. We conclude that, because Dr. Campagna later found no evidence of the pedicle fractures, Dr. Gilmore's opinion regarding the new injury carries little or no weight.

Under the circumstances, the employer has failed to carry its burden of proof regarding the compensability of claimant's June 1990 low back injury claim. Accordingly, the employer is bound by its acceptance of the June 1990 new injury claim and the back-up denial must be set aside.

Responsibility

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". ORS 656.308(1). Here, there is no contention that after the June 1990 compensable injury, claimant sustained a new compensable injury involving the same condition in some subsequent employment. Accordingly, as the last carrier against whom claimant had an accepted low back injury, the employer is and remains responsible for the medical services and disability relating to the accepted low back condition. Richardo Vasquez, 43 Van Natta 1628 (1991); Rosalie Drews, 44 Van Natta 1261 (1992).

We further conclude that claimant is entitled to an attorney fee for services on Board review. Both Industrial Indemnity and the employer denied compensability and no .307 order issued. Thus, claimant's right to compensation was at risk at the 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 the self-insured employer 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 the employer sought Board review and was ultimately found responsible, it is also responsible for the assessed attorney fee for services on 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 $800 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 November 19, 1991 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $800, payable by the self-insured employer.

In the Matter of the Compensation of
GARY C. FISCHER, Claimant
WCB Case No. 91-08489
ORDER ON REVIEW (REMANDING)
Hollis Ransom, Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Davis's order that: (1) dismissed his 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

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

Claimant requested reconsideration of the Determination Order using the form provided by WCD.

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, found that the matter remained with the Appellate Review Unit, 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 May 21, 1991 Order on Reconsideration are applicable. Former OAR 436-30-003(4) (WCD Admin. Order 7-1990, effective July 1, 1990).

We have recently held 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 attending physician's medical findings of 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 state "whether there is a 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 by checking a box on the WCD form which provided that reconsideration was requested because claimant disagreed with the rating of disability by Evaluations. Additionally, claimant attached a letter to the form which described the problems he was experiencing with his left eye and the fact that he had been required to make adjustments to his daily routine to compensate for his loss of vision. Nowhere on the form or claimant's letter did claimant disagree with the impairment findings of his attending physician. To the contrary, claimant left unmarked the box indicating disagreement with his attending physician's impairment findings.

Under the circumstances, we find that claimant's WCD form and the accompanying letter were sufficient to initiate the reconsideration process. However, claimant did not disagree with the impairment findings of his attending physician, as required by former OAR 436-30-050(4)(d). See Carter, supra; Charles R. Butler, 44 Van Natta 994 (1992). Furthermore, on review, claimant reiterates that the only issue in this case is how the treating physician's findings were applied, not whether the findings were correct. We also agree with claimant that he did not impliedly object to the impairment findings of his physician by checking the box that states that he disagreed with the award of scheduled permanent disability. Finally, we agree with claimant's contention that no request for a medical arbiter was ever made. Therefore, the Director was not required to submit the matter to a medical arbiter prior to issuing the Order on Reconsideration. Carter, supra; Butler, 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, the Referee dismissed claimant's hearing request and concluded the hearing without permitting the parties 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.

In remanding this matter, we note that, at hearing, claimant submitted an exhibit that originated after the Order on Reconsideration was issued. The relevant statute, ORS 656.268, provides that 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. Accordingly, as we have above determined that the Order on Reconsideration was valid, we conclude that it follows that the exhibit consisting of subsequent medical evidence of claimant's impairment is not admissible. See ORS 656.268.

We therefore 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 6, 1991 is vacated. The matter is remanded to Referee Davis for further proceedings consistent with this order.

In the Matter of the Compensation of
JAVIER GARIBAY, Claimant
WCB Case No. 90-21498
ORDER ON REVIEW
Ginsburg, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of that portion of Referee Garaventa's order that declined to grant permanent total disability for a right wrist injury. The self-insured employer cross-requests review of that portion of the order that directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree. On review, claimant argues that the Referee abused her discretion in admitting evidence from the self-insured employer's vocational experts. The issues on review are rulings on evidence, permanent total disability, and rate of scheduled permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

On review, claimant argues that the Referee abused her discretion in: (1) admitting exhibit 52, a report from one of the employer's vocational experts; (2) allowing Mr. Sakagawa and Mr. Alverson, vocational experts, to testify when the employer failed to timely notify claimant of its intent to have vocational experts testify; and (3) allowing Mr. Inman, the employer's risk manager, to testify as a vocational expert.

Regarding Exhibit 52, this document was admitted without objection. (Tr. #1, p. 188). Having failed to object to this document at hearing, claimant is precluded from raising the objection on review. See Joseph B. Beaulieu, 40 Van Natta 1199, 1200 (1988).

Regarding the testimony of Mr. Sakagawa and Mr. Alverson, pursuant to OAR 438-07-016 and 438-07-018, the employer was required to give claimant notice of its intent to call expert witnesses 20 days before the hearing. The employer did not meet this requirement. However, OAR 438-07-016 also provides that:

> "At the hearing the referee may, in his or her discretion, allow the testimony of expert witnesses not disclosed as required by this rule. In the exercise of this discretion, the referee shall determine whether material prejudice has resulted from the timing of the disclosure and, if so, whether there is good cause for the failure to timely disclose that outweighs the prejudice to the other party or parties."

The Referee determined that no material prejudice resulted from the timing of the disclosure and that, even if material prejudice resulted, there was good cause for the failure to timely disclose that outweighed the prejudice to claimant. (Tr. #1, p. 9-10). Regarding the question of good cause, the Referee found that, because of the nature of this case, there was no documentary vocational evidence in the record (claimant having never been referred for vocational assistance). Not knowing to what specific issues or matters claimant's own vocational expert witness would testify, the employer did not know what expert testimony would be needed and belatedly decided to have vocational experts attend the hearing, listen to the testimony from claimant's experts, and provide a response.

Given these findings, we cannot say that the Referee abused her discretion in allowing the employer's vocational experts to testify. Furthermore, we note that the second day of hearing was held three months later and claimant's vocational expert was given the opportunity to rebut the employer's experts' testimony.

Finally, regarding the testimony of Mr. Inman, claimant contends that the Referee erred in allowing Mr. Inman to testify as a vocational expert. We disagree with claimant's characterization of Mr. Inman's testimony. Mr. Inman has some experience as a vocational counselor. However, he is the employer's risk manager and most of his testimony dealt with his opinion as to what work the employer had that claimant would be able to perform. At one point, Mr. Inman offered his opinion regarding cannery work based primarily on his experience as a teenager driving a truck for a cannery. In response to claimant's objection, the Referee allowed Mr. Inman's testimony but stated that the objection went to its weight.

A 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). Given this, and in light of the fact that the Referee limited the weight to be given to Mr. Inman's testimony regarding his knowledge of cannery jobs, we do not find that the Referee abused her discretion in allowing Mr. Inman's testimony. Furthermore, we do not find that the Referee gave Mr. Inman's testimony any undue weight.

Permanent Total Disability

We adopt the Referee's reasoning and conclusions regarding the issue of permanent total disability with the following supplementation.

The hearing took place over two days, three months apart. At the first day of hearing one of the employer's experts identified two employers as willing to consider claimant with his limitations. However, the jobs at these two employers involved driving a lawn tractor. Because claimant cannot drive, it was not unreasonable for him not to contact these potential employers. However, with this exception, we agree with the Referee that the record demonstrates that claimant is not willing to work and his efforts to obtain employment have not been reasonable.

This conclusion is based on the following. In December 1987, claimant refused an offer of a job with the at injury employer that his treating physician had approved as being within his physical capacities. From the time he refused that job offer through the first day of the hearing, a period of about three and a half years, claimant did not look for work. Following the first day of the hearing, on the advice of his attorney, claimant looked for work. He did not contact the at-injury employer. Furthermore, he did not contact any canneries, a source of employment identified by vocational experts during the first day of hearing. Canneries were hiring at the time of claimant's job search. In addition, although claimant's job search efforts were directed primarily at seasonal employers who claimant admitted he knew were not hiring at the time, two employers stated that they had no work at present but asked claimant to return. Claimant did not return to or inquire further of these potential employers.

Rate of Scheduled Permanent Disability

The Referee concluded that claimant's award of scheduled permanent disability should be paid at the rate of $305 per degree. The Referee relied on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), in which we held that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. Subsequent to the Referee's order, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992).

In this case, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury. ORS 656.202(2); Former ORS 656.214(2).

ORDER

The Referee's order dated October 3, 1991 is affirmed in part and reversed in part. That portion of the order that directed the self-insured employer to pay the scheduled permanent disability at the rate of $305 per degree is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
IRWIN W. GEER, Claimant
WCB Case Nos. 92-01980 & 91-17845
ORDER OF ABATEMENT
Kirkpatrick & Zeitz, Claimant Attorneys
Beers, et al., Defense Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Claimant requests abatement of our July 22, 1992 Order of Dismissal which dismissed the SAIF Corporation's July 10, 1992 request for Board review. Reasoning that the Referee's May 13, 1992 Opinion and Order had become final by operation of law, we held that we lacked jurisdiction to consider SAIF's request for review. Claimant seeks abatement of our order to permit him "an opportunity to brief this substantial legal issue." In addition, apparently in response to our July 22, 1992 decision, the Referee has issued a July 28, 1992 Order of Dismissal. Claimant has requested Board review of the Referee's recent dismissal order.

In light of such circumstances, we grant claimant's request to provide his written position regarding the finality of the Referee's May 13, 1992 Opinion and Order and our authority to consider the matter.

Accordingly, our July 22, 1992 order is withdrawn. Claimant's written response shall be due 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN B. GORDON, Claimant
WCB Case No. 91-10971
ORDER DENYING RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

Claimant has requested reconsideration of our July 28, 1992 Order on Reconsideration which held that claimant's scheduled permanent disability award should be paid at a rate of $145 per degree. In that order, we relied on the Court of Appeals' recent decision in SAIF v. Herron, 114 Or App 64 (1992). Claimant requests that we abate our order and hold this matter in abeyance pending the final resolution of SAIF v. Herron, supra. We deny claimant's request.

As an adjudicative body, our function is to resolve disputes brought to us by the litigants. In performing these duties, we apply the relevant statutory, administrative, and judicial precedents as they exist at the time of our review. In this way, the litigants are advised in a prompt and orderly manner, and are able to readily determine what further action they wish to take in pursuing their respective remedies. Were we to follow claimant's suggestion and hold this matter in abeyance, resolution of this dispute, as well as numerous others, would be deferred for an indeterminate period awaiting another appellate forum's decision. We do not consider such an action consistent with our statutory role as a decision-maker. See Alfonso S. Alvarado, 43 Van Natta 1303 (1991). We note parenthetically, however, that the Board has approved settlements concerning this issue whereby the parties' agreement is contingent on the final resolution of the Herron case. See e.g. Shirley A. Roth, 43 Van Natta 1802 (1991).

Moreover, we note that the Court of Appeals is applying the Herron decision without awaiting further procedural developments. See e.g. National Union Insurance Company v. Crowder-Hicks, 114 Or App 426 (1992); Trees, Inc. v. Long, 114 Or App 429 (1992); Liberty Northwest Insurance Corporation v. Lepley, 114 Or App 428 (1992). We find no reason to stray from the Court's example.

Accordingly, claimant's request for reconsideration is denied. The parties' rights of appeal shall continue to run from the date of our July 28, 1992 Order on Reconsideration.

IT IS SO ORDERED.

August 7, 1992 Cite as 44 Van Natta 1602 (1992)

In the Matter of the Compensation of
JON T. MARS, JR., Claimant
WCB Case No. 91-09812
ORDER ON REVIEW
Merrill Schneider, Claimant Attorney
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Lipton's order that declined to assess attorney fees for: (1) an alleged "de facto" denial of a surgery request; and (2) the alleged unreasonableness of this alleged "de facto" denial. On review, the issue is attorney fees.

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

A prior referee's order found the SAIF Corporation responsible for claimant's "current right knee condition." Although the prior referee stated that "further surgery appears likely and claimant would like to have that surgery," there was no surgery request in existence at the time of hearing and the prior referee did not direct SAIF to process a surgery claim. Instead, following the issuance of the prior referee's order, claimant's attending physician sought authorization to perform surgery for the compensable right knee condition. Within 60 days of that request, SAIF provided the requested authorization.

Under such circumstances, we conclude that claimant's hearing request from the alleged "de facto" denial was premature. See Michael A. Dipolito, 44 Van Natta 981, 982 (1992). Furthermore, considering that SAIF timely responded to the attending physician's surgery request, we do not find SAIF's conduct to have been unreasonable.

ORDER

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

August 7, 1992 Cite as 44 Van Natta 1602 (1992)

In the Matter of the Compensation of
DANA R. STALCUP, Claimant
WCB Case No. 91-02958
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Eileen G. Simpson, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee Brittingham's order which set aside its denial of claimant's occupational disease claim for a bilateral hand, wrist and forearm condition. On review, the issue is compensability.

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

The employer contends that claimant's condition cannot be compensable because there is no definitive diagnosis. We do not find this argument persuasive. The medical evidence establishes

"carpal tunnel syndrome" as at least a working diagnosis of claimant's condition. Claimant's condition has some atypical features, and her condition was "mild" rather than "full-blown" when she sought treatment and when she was evaluated by independent medical examiner Dr. Nathan. Nevertheless, the preponderance of medical evidence identifies her condition as carpal tunnel syndrome (CTS). (See Exs. 2, 6, 7-1, 8-2, 10-4, 17-2, 20-1).

Moreover, a definitive diagnosis is not required in order to establish compensability. Claimant need only establish, by medical evidence supported by objective findings, that work activities were the major contributing cause of her disability or need for medical treatment. ORS 656.802(1)(c), (2); see also JoAnn Fryman, 44 Van Natta 1122, 1124 (1992), citing Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988).

Here, we find that the medical evidence establishes that claimant's bilateral hand, wrist and forearm symptoms were caused in major part by her work activities. Dr. Butters, a consulting orthopedist, opined that work was the major contributing cause of claimant's carpal tunnel syndrome, noting that claimant's symptoms did not preexist her employment, that they were not the result of a systemic disease, and that there was no off-work exposure that was responsible for her problem. (Ex. 20-1). There is no contrary medical opinion.

Although Dr. Nathan opines that work activities did not cause or worsen any underlying condition, we do not find his opinion contrary to that of Dr. Butters. (Ex. 10-4). Dr. Nathan did not identify any underlying condition. However, he did attribute claimant's symptoms to work activity, noting that claimant related the onset of her symptoms to work and suggesting that a different type of work would alleviate her symptoms sufficiently to avoid surgery. (Ex. 10-4). Since it is claimant's symptoms which cause disability and the need for treatment, and which she is seeking to establish as a compensable disease, we find that Dr. Nathan's opinion is consistent with Dr. Butters' opinion that work was the major contributing cause of claimant's condition. See Georgia-Pacific Corp. v. Warren, 103 Or App 275 (1990) (Symptom complex known as carpal tunnel syndrome was compensable, despite medical opinion identifying an underlying "entrapment neuropathy" as a separate condition unrelated to work).

The employer next contends that even if Dr. Butters' opinion establishes the compensability of claimant's left-handed CTS condition, the evidence does not establish a compensable, bilateral condition. We disagree. Although Dr. Butters addresses only the left hand, wrist and forearm, we find that the medical evidence as a whole establishes compensability of a bilateral condition. Dr. Jefferson, claimant's initial treating doctor, prescribed wrist braces for both arms. (Exs. 1, 2). Dr. Mundall, consulting neurologist, diagnosed bilateral hand pain and numbness; probable carpal tunnel syndrome. (Ex. 8-2). Dr. Nathan found positive signs for carpal tunnel syndrome bilaterally. (Ex. 10).

Claimant explained that she is left-handed, and that she first noticed symptoms in her left hand, followed later by right-handed symptoms. (Tr. 8-10; see also Ex. 10-1). We note that Dr. Butters examined claimant in February 1991, after she had been off work for approximately 2 months. Claimant testified that her symptoms improved but did not completely resolve when she was not working, but that her symptoms again worsened when she returned to work doing the same job. (Tr. 10-11). Such circumstances persuade us that claimant's right-handed condition may not have been symptomatic at the time of Dr. Butters' examination. Nevertheless, prior to Dr. Butters' examination, claimant was treated for a bilateral condition, which the preponderance of the persuasive medical evidence relates to claimant's work activities. Accordingly, we conclude that claimant has established compensability of a bilateral condition.

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 is $1,525, 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.

ORDER

The Referee's order dated November 19, 1991 is affirmed. Claimant's attorney is awarded $1,525 for services on Board review, to be paid by the self-insured employer.

In the Matter of the Compensation of
PETE TOPOLIC, Claimant
WCB Case No. 90-14609
ORDER ON REVIEW
Hower & Munsell, Claimant Attorneys
David Schieber (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Moller.

Claimant requests review of those portions of Referee Mongrain's order, as amended, that: (1) declined to grant unscheduled permanent partial disability; (2) declined to grant permanent total disability; and (3) increased claimant's scheduled permanent partial disability award from 12 percent (18 degrees), as awarded by a Determination Order, to 30 percent (45 degrees). Claimant asserts that he is entitled to unscheduled permanent disability and an increased award of scheduled permanent disability or, alternatively, permanent total disability. On review, the issues are extent of unscheduled and scheduled permanent disability and entitlement to permanent total disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matter

In their briefs, both parties demonstrate some confusion as to whether the deposition transcript of Jane Hagle was admitted at hearing. Although the hearing transcript does not reflect whether or not the document was marked or formally received, we note that the Referee referred to this document in his order, although erroneously citing it as Exhibit 58 (a videotape) rather than Exhibit 59. (O & O at 3). Moreover, the document was included in the record certified by the Referee under ORS 656.295(3). Finally, the parties do not object to our consideration of the document on review. Accordingly, we conclude that the deposition transcript is properly included in the record and we consider it on review. See Nellie M. Ledbetter, 43 Van Natta 570, 571 (1991).

Unscheduled permanent partial disability

Claimant contends that he is entitled to unscheduled permanent disability based on a letter from his treating physician, Dr. Gilsdorf, orthopedic surgeon. In that letter, Dr. Gilsdorf stated that he had reviewed the Board's order in John Cameron, 34 Van Natta 211 (1982), and, based on his understanding of that order, found that claimant's "condition would be in both categories of scheduled and unscheduled." (Ex. 44-2).

We are not persuaded by Dr. Gilsdorf's opinion. First, we are hesitant to defer to the legal opinion of a physician, who may or may not have fully understood the legal meaning of a prior Board order. Furthermore, we find that the order in John Cameron is distinguishable from the case presented here. In Cameron, the Board examined whether an injury to the claimant's acetabulum, part of the hip joint, and "os coxae," made up of the pubis, ischium and ilium, constituted scheduled body parts. With little discussion, the Board determined that the injuries were to unscheduled portions of the body. 34 Van Natta at 212. Here, as provided by Dr. Gilsdorf, claimant's injury involved "comminution" or "multiple fracturing through the greater trochanter," a separate body part not discussed in (Ex. 44-1). Dr. Gilsdorf's understanding of Cameron does not aid us in our analysis.

Subsequent orders, however, have discussed whether the "trochanter" is scheduled or unscheduled. For instance, in Richard L. McMillan, 40 Van Natta 1241, 1244 (1988), the claimant's injury involved a fracture between the greater trochanter and the lesser trochanter. Based on both trochanters being located at the top of the femur, or upper leg bone, the Board found that claimant suffered a scheduled injury to the leg. Id. That holding is consistent with former OAR 436-35-130(1), which provides that the "leg begins with the femoral head and includes the knee joint."

We conclude that the present claimant's injury was to the "leg," which is a scheduled body part. We, therefore, agree with the Referee's conclusion that claimant is not entitled to an award of unscheduled permanent disability.

Permanent Total Disability

Claimant next asserts that he is entitled to permanent total disability based on a combination of his physical condition and nonmedical factors, such as his limited reading, math, dexterity, and other mental skills. He asserts that these vocational/education deficits prevent him from obtaining gainful employment.

Claimant has participated in several vocational tests. In November 1989, the Northwest Pain Center administered a variety of tests, finding that claimant had "average finger dexterity but significantly below average manual dexterity and fine motor coordination." (Ex. 18-1). His reading, spelling and arithmetic skills were at the third grade level. (Id). Claimant also demonstrated difficulty with problem solving. (Id. at 2).

In January 1991, Emanuel Hospital conducted a vocational assessment, finding that claimant's skills did not "readily transfer to the light range" and that he was "functionally illiterate in the English language." (Ex. 49-4).

In February 1991, Dr. Taylor, neuropsychologist, conducted a psychodiagnostic review, administering a series of tests. Dr. Taylor's report found that claimant had "marked limitations in his academic functioning, i.e., reading, writing, spelling, and arithmetic[.]" (Ex. 50-17). The report further stated that, given claimant's "functional limitations in basic skills, he would find it very difficult to find suitable and feasible employment in the competitive job market[.] * * * On the other hand, he appears sufficiently able intellectually to engage in employment, given a physical clearance, at a level that would not demand substantially greater cognitive abilities than his life-long occupational activities where he found success." (Id. at 19).

Finally, on referral from claimant's vocational counselor, further tests were administered, which determined claimant's reading to be at a 1.7 grade level, his math to be at a 3.4 grade level, his written language to be at a 1.0 grade level, and his knowledge to be at a 2.9 grade level. (Ex. 50a-1).

Bruce McLean, vocational consultant, evaluated claimant and testified on his behalf. Based upon the test results and claimant's physical capacity, McLean found that claimant was not competitively employable without vocational counseling and that without such counseling, claimant could only be hired in a "one-of-a-kind" job that matched his vocational profile. (Tr. 116).

McLean's opinion was opposed by that of claimant's vocational counselor, Jane Hagle, who reported that claimant was not "a permanent and total disability candidate." (Ex. 53-2). Hagle found that claimant's test results were not consistent with his work history and other accomplishments. (Id). Hagle further reported that claimant's "ability to communicate, fueled by the moxie, drive and intelligence native to [claimant], make him one of the least likely PTD candidates." (Id).

Although Hagle completed her report after seeing claimant on two occasions, (see Ex. 59-43), she later saw him again on at least six more occasions and spoke with him on the telephone. (Id. at 27-28). As before, Hagle continued to opine that claimant's test results were not accurate measures of his skills, (Id. at 39).

Finally, Scott Stipe, vocational consultant, evaluated claimant on behalf of SAIF. He reported that claimant "has shown via analysis of * * * past relevant vocational experience in comparison to

present functioning ability that [he] can be considered employable in a broad array of light and sedentary occupations which would require little, if any, reading." (Ex. 49D-13). At hearing, Stipe testified that he found the employment history to be a more reliable indicator of claimant's aptitude to perform work than the test results. (See Tr. 157).

The Referee relied on the opinions of Hagle and Stipe, along with his own observation of claimant, to conclude that claimant was not prohibited from obtaining gainful employment. Specifically, the Referee found that Hagle "had the greatest opportunity to personally evaluate" claimant and agreed with her that the test results did not reflect claimant's assets.

Claimant objects to the reliance on Hagle's opinion, asserting that her report was based on erroneous information and that the record contained no evidence as to the extent of her contact with claimant.

Hagle's deposition testimony reveals that she met with claimant twice before she prepared her report. More important, at the deposition, Hagle continued to hold the opinion that claimant was not permanently and totally disabled and that claimant's test results were not consistent with his actual abilities. By the time she was deposed, she had met with claimant six times. Thus, she had more contact with claimant that did McLean and Stipe. Moreover, the one error cited by claimant contained in Hagle's report was not relied upon by Hagle in determining claimant's vocational opportunities. Therefore, we agree with the Referee that Hagle's opinion is entitled to the greatest weight. Based on that evidence, along with the supporting opinion of Stipe, we conclude that claimant is not permanently totally disabled.

Scheduled Permanent Disability

Finally, claimant seeks an increased award of scheduled permanent disability. Specifically, he seeks additional impairment based on evidence that his injured left leg is longer than his right leg, decreased left leg flexion, atrophy of the left leg, and disabling pain resulting in a limp.

Although we agree that claimant has a documented difference in leg length, (Exs. 46-5, 51-2), there is no persuasive evidence that such difference is due to his compensable injury. We also agree that a limp has been documented. (Ex. 51-2). However, that condition appears to be attributed to the difference in leg length; there is no persuasive evidence that claimant limps due to disabling pain. (See Id. at 2, 3). Furthermore, although a December 1989 report shows differences in flexion between claimant's left and right knees, (Ex. 25), the most recent report does not document loss of flexion in the knee, (see Ex. 51-2). Finally, we agree with the Referee that, because claimant's atrophy is not located in the foot or thigh, he is not entitled to an award for that condition under the standards. See former OAR 436-35-230(5). Therefore, finding no other basis for increasing the award, we affirm the Referee's award of scheduled permanent disability.

ORDER

The Referee's order dated July 19, 1991, as amended on August 30, 1991, is affirmed.

In the Matter of the Compensation of
JEANNIE L. SHELTON, Claimant
And, In the Matter of the Complying Status of
JOHN T. and FAY E. JENSEN, Employers
WCB Case Nos. 91-00894 & 90-21423
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
David Ray Fowler (Saif), Defense Attorney
O'Neill, et al., Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of those portions of Referee Spangler's order which: (1) upheld the SAIF Corporation's denial of her injury claim; and (2) declined to award an attorney fee for claimant's counsel's services on the issue of noncomplying employer status. 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" with the following exceptions. Claimant did not misappropriate the group home residents' food stamps. Claimant did not participate in a scheme to conceal this misappropriation from state officials. Reeves, her boyfriend, advised Mr. Jensen, the owner of the group home, of claimant's slip and fall at the home within three days of the incident. Claimant began working as a maid on September 21, 1990.

We add the following finding of ultimate fact. Claimant suffered an injury while performing her work activities, which was a material contributing cause of her disability and need for medical treatment.

CONCLUSION OF LAW AND OPINION

The Referee was not persuaded that claimant had sustained a compensable injury. In reaching that conclusion, the Referee found that claimant was not a credible witness. The Referee based that finding on the substantive record, not on claimant's demeanor. Under such circumstances, we are equally competent to evaluate the substance of claimant's testimony. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

After conducting our review, we do not find claimant's version of the events surrounding the work incident to lack reliability or credibility. Furthermore, since the medical evidence is consistent with claimant's version of the incident, we are persuaded that claimant's injury claim is compensable.

In questioning claimant's credibility, the Referee listed six specific grounds. We shall briefly discuss each basis and provide our own reasoning for each point.

Based on the testimony of the Jensens, claimant's employers, the Referee found that claimant and her boyfriend (Reeves) were misappropriating food stamps from the residents of the group home that claimant and Reeves were managing for the Jensens. The Referee was also persuaded that claimant and Reeves cooperated in a scheme to conceal this misappropriation from state officials.

There is evidence that food stamps from some of the residents were used for purchasing groceries for the home. However, Ms. Jensen testified that such a practice was in place prior to her ownership of the home, as well as her hiring of claimant and Reeves. Furthermore, most of the groceries were purchased by the Jensens, who were responsible for the funding of all home supplies. Finally, any suggestion concerning a "concealment" scheme would be attributable to Reeves, not to claimant.

The Referee also questioned claimant's credibility because, although she was familiar with the workers' compensation system, she did not report her injury to the Jensens until several days after her slip and fall incident nor did she immediately seek medical treatment. We find understandable explanations for these circumstances.

To begin, Reeves notified Mr. Jensen of the incident within three days of the event. In addition, claimant lacked insurance and, considering the unclear nature of her business arrangement with the Jensens (independent contractor v. employee), she was uncertain whether her medical expenses would be paid by the Jensens. Claimant also testified that she was too sore to walk, as well as self-conscious about her appearance, for several days following the incident. Finally, once claimant sought treatment, her accounts of the work incident were consistent.

Following the August 17, 1990 work incident, claimant testified that, until September 5, 1990, she was in such pain that the only chore she could perform at the group home was dispensing medication to the residents. The Referee found that this testimony lacked credibility because claimant began working as a maid on "September 1, 1990." Inasmuch as claimant began her employment as a maid on September 21, 1990, not September 1, 1990, we do not share the Referee's skepticism concerning claimant's testimony.

The final reason that the Referee gave for discounting claimant's testimony was that, following her termination by the Jensens, she had threatened to "do something [to the Jensens] to get even." According to the Jensens, this threat occurred in September 1990. Thus, this exchange took place approximately one month after claimant's August 1, 1990 termination notice, as well as some two weeks after the August 17, 1990 work incident, claimant's first medical treatment, and the Jensens' first notice of the incident. Such circumstances do not cause us to question claimant's credibility.

Based on claimant's version of the events surrounding the August 17, 1990 slip and fall incident and considering the medical evidence which is consistent with claimant's account, we find that claimant suffered an accidental injury arising out of and in the course and scope of employment. ORS 656.005(7)(a). Moreover, we are persuaded that claimant's work incident was a material contributing cause of her need for medical services and disability. Id; Mark N. Wiedle, 43 Van Natta 855 (1991). Finally, based on her physicians' observations and conclusions, claimant's injury has been established by medical evidence supported by objective findings. Suzanne Robertson, 43 Van Natta 1505 (1991). Accordingly, SAIF's denial of claimant's injury claim is set aside.

Attorney Fee

Claimant contends that the Referee erred in failing to award attorney fees for claimant's success in overturning the Jensens' challenge to the Director's noncompliance order. We disagree.

ORS 656.382(2) provides that claimant may receive an attorney fee if an insurer or employer requests a hearing, and the Referee finds that the compensation awarded to claimant should not be disallowed or reduced. Here, in upholding SAIF's denial on the Jensens' behalf, the Referee effectively found the compensation claimant was seeking should be disallowed. Accordingly, we do not find that ORS 656.382(2) provides a basis for an attorney fee for claimant's counsel's services on the issue of the employer's noncomplying status.

Nevertheless, for finally prevailing against SAIF's compensability denial, 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 $3,000, to be paid by SAIF on behalf of the noncomplying employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellant's brief), the complexity of the issue, the value of the interest involved, and the risk that claimant might go uncompensated.

ORDER

The Referee's order dated May 10, 1991 is reversed in part and affirmed in part. The SAIF Corporation's denial on behalf of the noncomplying employer 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 issue, claimant's counsel is awarded an assessed fee of $3,000, to be paid by SAIF on behalf of the noncomplying employer. The remainder of the order is affirmed.

In the Matter of the Compensation of
OLGA I. SOTO, Claimant
WCB Case No. 91-12369
ORDER DENYING RECONSIDERATION
Michael B. Dye, Claimant Attorney
Thomas E. Ewing (Saif), Defense Attorney

The Director of the Department of Insurance and Finance (DIF) has requested reconsideration of the Board's April 7, 1992 Order on Review which affirmed a Referee's 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). DIF seeks its joinder as a party to this proceeding. In addition, relying on the dissenting opinion included in the Board's order as well as the "Position Statement" previously submitted by the Department, DIF contends that the Board's order "misapplie [sic] Oregon law, creates an unduly burdensome process of review inconsistent with legislative intent and exceeds Board authority."

Prior to the filing of DIF's request, claimant and the SAIF Corporation petitioned the Court of Appeals for judicial review of our order. Furthermore, the 30-day period within which to withdraw and reconsider our order has expired. SAIF v. Fisher, 100 Or App 288 (1990). Thus, jurisdiction over this matter currently rests with the court. ORS 656.295(8); 656.298(1). Nevertheless, at any time subsequent to the filing of a petition for judicial review and prior to the date set for hearing, we may withdraw an appealed order for purposes of reconsideration. ORS 183.482(6); ORAP 4.35; Glen D. Roles, 43 Van Natta 278 (1991). However, this authority is rarely exercised. Ronald D. Chaffee, 39 Van Natta 1135 (1987).

To begin, before the Board conducted its review of this case, DIF made a similar request for joinder. DIF was notified, through the Board's staff counsel, that since this proceeding did not arise from a hearing request filed by the Director, the Board had concluded that the Director was not a party. ORS 656.005(20); 656.283(1). Although the request for joinder was rejected, DIF was permitted to submit its written position concerning the matters at issue. Thereafter, DIF filed its "Position Statement," which was considered by the Board in conducting its review.

DIF seeks its joinder as a party "so that [DIF], in its own right, may address, and seek review of, those issues regarding its jurisdiction and statutory responsibilities." We decline to grant the request. First, since the Director was not a party to the hearing which began this process, we are not inclined to include the Director as a party at this late date. Moreover, our rejection of the joinder request would not foreclose the Director from addressing the issues in this case at the appellate court level. See ORAP 8.15 (Amicus Curiae).

DIF further contends that the Board's order is inconsistent in that, while holding that the Hearings Division lacked jurisdiction to consider the appeal from an invalid Order on Reconsideration, the Board also remanded the case to the Director. DIF misinterprets our decision. We concluded that, since the Order on Reconsideration issued without benefit of a medical arbiter, the reconsideration order was invalid. Thus, we held that jurisdiction over the case remained with the Director. Inasmuch as jurisdiction has never left the Director, our order did not purport to "remand" the case to the Director.

DIF also argues that inasmuch as the Order on Reconsideration was issued in compliance with a Circuit Court order, the Director was excused from complying with ORS 656.268(7). We disagree. In Benzinger v. Oregon Dept. of Ins. and Finance, 107 Or App 449 (1991), the Court of Appeals affirmed a Circuit Court decision which ordered DIF to issue Orders on Reconsideration in compliance with the time limit set forth in ORS 656.268(6)(a). In so doing, the court rejected DIF's argument that it was excused from complying with ORS 656.268(6)(a) because of the difficulty involved in issuing an Order on Reconsideration within the mandatory time period. Id.

Implicit in the court's decision is the assumption that DIF will issue a valid Order on Reconsideration in accordance with all statutory prerequisites and within the statutory time limits. To conclude otherwise would allow DIF to ignore one mandatory statutory provision, ORS 656.268(7), in

order to comply with another mandatory statutory provision, ORS 656.268(6)(a). We would not interpret the court's directive in such a manner.

Furthermore, DIF's argument appears to parallel the argument made to the Benzinger court concerning DIF's logistical and practical difficulties in issuing Orders on Reconsideration within the time limits imposed by the statute and enforced by the court. As the Benzinger court reasoned in rejecting such an argument, compliance with the court's order may be difficult. Nevertheless, the statutory requirement is mandatory and must be complied with. Benzinger, supra; see also Dept. of Rev. v. Carpet Warehouse, 296 Or 400, 404 (1984).

Finally, we decline DIF's invitation to follow the reasoning set forth in the dissenting opinion in the Board's April 7, 1992 order. In this regard, we would further note that the dissent's reasoning, as well as the "Position Statement" offered by the Department, were fully considered in reaching the Board's prior conclusion.

Accordingly, DIF's motion for reconsideration is denied. The issuance of this order neither "stays" our prior order nor extends the time for seeking review. International Paper Company v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 545 (1985).

IT IS SO ORDERED.

Board Member Kinsley concurring in part and dissenting in part.

I agree with the majority that the Department's motion requesting that it be joined as a party to this proceeding should be denied. ORS 656.005(20). I note, as did the majority, that denial of this motion does not preclude the Department from making its arguments as amicus curiae in this case which is currently pending at the Oregon Court of Appeals. ORAP 8.15.

As to the merits of the underlying case, I continue to adhere to my dissenting opinion in the April 7, 1992 Order on Review. There is no question that, given the issues presented in this case, the Department should have referred this claim to medical arbitration while it was pending reconsideration at the Appellate Unit.[1] However, I can find no statutory authority that would allow the Board to remand this case to the Department and order it to refer the claim for medical arbitration. Neither do I find any authority for the Board itself to refer the claim for medical arbitration. However, the Board does have the authority to resolve disputes by conducting hearings in the Hearings Division. Because the claim has not been referred for medical arbitration, there is no limitation on the evidence that may be presented at hearing on the issue of claimant's permanent disability. See ORS 656.268(7). Therefore, the parties should be allowed to present and develop this evidence in a full hearing at the Hearings Division. I would remand this case to the Hearings Division for that purpose.

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[1] I recognize that the trial court in the Benzinger case handed the Appellate Unit the formidable (some would say impossible) task of processing a large number of cases, such as the instant case, in a very short period of time.

Board Member Hooton specially concurring.

I agree with the denial of reconsideration in this case. However, I do so for reasons which differ somewhat from those expressed in the majority's politic opinion. I also frankly acknowledge a desire to utilize the forum available in a special concurrence, a forum which permits use of the pronoun "I", to express a view not previously advanced or considered.

As a recent appointee, I did not have the opportunity to fully participate in the Order on Review in this case. I therefore note for the record that, because I do not agree with the position taken, I could not have been a member of the majority in that decision. Neither do I lend complete allegiance to the position taken by Board members Kinsley and Tenenbaum in their well-reasoned dissent.

The Department of Insurance and Finance (DIF) argues that the Board should look to the purposes and objectives of the Worker's Compensation Law in construing the requirements of the 1990 amendments. It relies specifically upon the objective stated in ORS 656.012 (2)(b) that the purpose of

the Law is "[t]o 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." It alleges that, as a consequence of this provision, "it is incumbent upon an adjudicative body to interpret the act in a common sense fashion that reduces unnecessary delays and complexities in resolving disputes." With the general statement of principle, I agree. With its application, I do not.

While the Board should use common sense and a general policy of eliminating unnecessary delays and reducing the complexity of proceedings as a quide in construing statutory requirements, it may not utilize those same considerations as an excuse to ignore or rewrite the express language of the statute. In addition, to the extent that these goals are applicable to the present dispute, they apply equally to an administrative agency whose actions are made an integral part of the review proceedings on the determination of disability. I note that the most propitious resolution to the present dispute which both provides claimant financial benefits in a timely manner and reduces litigation is the issuance of a valid Order on Reconsideration. The issuance of such an Order is solely in the Department's control.

DIF argues that the invalidation of an Order on Reconsideration "unnecessarily complicates the litigation process, deprives the parties of a speedy determination of disability and frustrates the legislative intent that litigation be minimized." Again, I agree.

DIF further argues that "a review process is designed to allow for the correction of errors in an underlying order. It is illogical to take the position that an underlying order must be 'perfect' before review can be had.... One presumes that the purpose of mandatory review is to provide a process to correct defective orders." Again, I agree. However, my agreement with the arguments presented by DIF does not lead me to the conclusion that DIF asserts.

I note that correction of a defect in an order on reconsideration can and should be accomplished by the Board in certain circumstances. For example, where it is apparent that the Appellate Unit inappropriately applied the rules or established an incorrect medically stationary date which effects entitlement to temporary disability, the Board can and should correct the error without invalidating the Order on Reconsideration. However, where the defect in the Order requires an additional procedure that is in the sole control and jurisdiction of the Director, the issue is not as simple.

The Board, and its referees, lack the authority to appoint a medical arbiter or to adopt temporary rules. Where the defect involves the failure of the Director to complete one of these statutory duties the only possible solutions available to correct the defect are either to ignore the language of the statute and proceed to try the case under the law as it existed prior to SB 1197, or to return the Order to the Director in some fashion. It is the duty of the Board to apply the law, not to ignore it. Consequently the first alternative, is no alternative at all. DIF disputes the Boards authority to accomplish the second under any circumstances.

DIF asserts that an Order on Reconsideration based on an invalid or incomplete proceeding is sufficient to meet the requirements of Benzinger v. Oregon Dept. of Ins. and Finance, 107 Or App 449 (1991). The majority disagrees and invalidated the Order on Reconsideration in the present claim. In keeping with my agreement with the assertion of DIF that "one presumes that the purpose of mandatory review is to provide a process to correct defective orders," I would find that the statute implicitly empowers the Board with remand authority, and the authority to require the Appellate Unit to make those corrections which are in its sole jurisdiction. Whether the Order on Reconsideration is invalidated or remanded however, is of no practical importance. The net effect remains that the determination of disability is in the Appellate Unit until a corrected Order on Reconsideration has issued.

DIF, and its Appellate Unit, continue to characterize the invalidation of an Order on Reconsideration as an Order of Remand. In light of Benzinger this is not surprising. By invalidating the Order on Reconsideration the majority of the Board has indicated that the Order is null and void and, therefore, an Order on Reconsideration has never issued. If the majority is correct, DIF remains in non-compliance with Benzinger, and, therefore, may be in contempt of court.

DIF also, however, denies the authority of the Board to remand an Order on Reconsideration to the Department for further action. It argues that it is not a party to the proceeding and has not consented to submit itself to the Board's jurisdiction. Absent these to preconditions, it argues that an Order of Remand is invalid.

Now DIF requests to be made a party to the proceeding and requests reconsideration so that "in its own right, [DIF] may address, and seek review of, those issues regarding its jurisdiction and statutory duties." It does not suggest that it will consent to the remand authority of the Board, or otherwise propose any resolution of the present dispute other than that the Board should adopt its position.

If DIF's interest in the present dispute is the development of a consistent and stable interpretation of the requirements of the statute to be applied at all levels of review on questions involving claim determination, the appropriate method of accomplishing that end was to seek the advise of the Board under ORS 656.726(2) prior to issuing its Order on Reconsideration.

If, on the other hand, its interest is the prompt and just resolution of the present dispute, I find that end best served by the issuance of an amended and correct Order on Reconsideration.

Presently, this claim is before the Court of Appeals. I believe that the interests of all parties concerned in this claim, and in all subsequent claims, are best served by permitting the court to promptly determine the respective rights and obligations of the parties. Withdrawing our prior Order for the purpose of reconsidering DIF's argument will necessarily delay the court's review and is unlikely to have any practical effect in resolving the claim since there is no evidence that DIF will acknowledge or accept a formal remand. Therefore, though I disagree with the majority position on the Board's remand authority and would, therefore, prefer to make DIF a party and formally remand the claim, I agree that reconsideration is inappropriate.

August 11, 1992 Cite as 44 Van Natta 1612 (1992)

In the Matter of the Compensation of
RITA M. PARKE, Claimant
WCB Case No. 91-04995
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Carol Taaffe (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Davis' order which upheld the SAIF Corporation's denial of claimant's low back 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 analyzed compensability of the claim under ORS 656.005(7)(a)(B), finding that the major contributing cause of claimant's symptoms was her preexisting degenerative disc disease. Claimant disputes the applicability of ORS 656.005(7)(a)(B), contending that her symptoms were due only to the injury to her back which resulted in a strain. Alternatively, claimant argues that if a preexisting condition combined with her back injury, the medical evidence proved that the back injury was the major contributing cause of her need for treatment and disability.

Compensability is determined under ORS 656.005(7)(a)(B) when "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." We have construed the statute as requiring a two-step determination. See Bahman N. Nazari, 43 Van Natta 2368, 2370 (1991). First, claimant must prove that the industrial accident is a material contributing cause of disability or need for treatment. Id. Then, in determining the compensability of the resultant condition, claimant must prove that the compensable injury, rather than the preexisting condition, is the major contributing cause of her disability or need for treatment. Id.

Here, we agree with claimant that she proved that her lumbosacral strain was a result of work activities on January 25, 1991. Her treating chiropractor, Dr. Villnave, diagnosed an "acute, moderate right iliolumbar strain" and attributed it to an industrial accident. (Ex. 5-2). Dr. Peterson, orthopedist, who conducted an independent medical examination, also found that claimant's "symptoms are entirely consistent with lumbosacral strain." (Ex. 7A-6). Based on this evidence, therefore, claimant proved a compensable injury, and SAIF's denial of a January 25, 1991 compensable injury shall be set aside.

We further find, however, that at hearing the parties litigated compensability of claimant's current condition under ORS 656.005(7)(a)(B). (Tr. 6-7). In this regard, the medical evidence supports the Referee's conclusion that claimant's compensable injury combined with a preexisting degenerative disc disease. The presence of such a disease was diagnosed by Dr. Corrigan, orthopedic consultant, on the basis of spinal x-rays. (Ex. 7-3). Dr. Peterson confirmed this diagnosis. (Ex. 7A-5). Moreover, Peterson found that claimant's lumbosacral strain was superimposed upon the degenerative disc disease, thus indicating that the two conditions combined. Peterson also concluded that "the major contributing cause of [claimant's] continuing back symptoms is degenerative disc disease at the lumbosacral level." (Id. at 6).

Although claimant argues to the contrary, we find that Dr. Peterson's report is most complete and well-reasoned and, therefore, provides the most persuasive opinion. See Somers v. SAIF, 77 Or App 259 (1986). We give Dr. Villnave's opinion lesser weight because, although the treating physician, his reports do not display a complete knowledge of claimant's condition or provide a well-reasoned explanation for his opinion. In an earlier report, Villnave states that the work activities of January 25, 1991 were "responsible for greater than 50% of current symptoms." (Ex. 3B-2). However, the report fails to refer to the degenerative disc disease or indicate that Villnave is aware of the condition. In a subsequent opinion, Villnave does refer to claimant's preexisting condition, but does not explain its contribution to claimant's symptoms other than to state that "the condition makes her low back less stable and easily susceptible to injury[.]" (Ex. 9-2).

We also do not give great weight to the opinion of Dr. Corrigan since he explicitly stated that his "evaluation was principally for that of evaluating the effects of her more recent low back reported occupational strain of 3/25/91." (Ex. 8). Corrigan thus offers no opinion regarding the compensable injury of January 25, 1991.

Therefore, we conclude that claimant proved a compensable injury. However, we further conclude that the compensable injury combined with the degenerative disc disease and that the major contributing cause of the resulting condition is the preexisting condition. Thus, claimant's current low back condition is not compensable. We note, parenthetically, that claimant is not precluded from establishing that only future disability and/or need for treatment is related, in major part, to the compensable injury and is, therefore, compensable.

Finally, because claimant proved the compensability of her back injury, claimant's attorney is entitled to a reasonable fee under ORS 656.386(1) for services at hearing and on review. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee is $1,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing transcript and claimant's appellant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated September 30, 1991 is affirmed in part and reversed in part. The SAIF Corporation's denial of a compensable January 25, 1991 injury is set aside and the claim is remanded to

SAIF for processing. For services at hearing and on review regarding the compensability of claimant's January 25, 1991 back injury, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the SAIF Corporation. SAIF's oral denial at hearing of claimant's current back condition is upheld. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
CAROLE A. VANLANEN, Claimant
WCB Case No. 91-13600
ORDER ON REVIEW
Galton, Scott & Colett, Claimant Attorneys
Julie K. Bolt (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Moller.

The SAIF Corporation requests review of Referee Mills' order that: (1) found that SAIF could not stay the payment of temporary and permanent partial disability compensation awarded in a Determination Order, pending SAIF's appeal of a prior Referee's Opinion and Order; and (2) assessed a penalty and attorney fee for SAIF's allegedly unreasonable failure to timely pay the awards made by the Determination Order. On review, the issues are stay of compensation, and penalties and attorney fees. 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 concluded that ORS 656.313, as amended by the 1990 amendments, did not allow SAIF to stay the payment of compensation awarded by an August 15, 1991 Determination Order by virtue of SAIF's request for Board review of a Referee's May 3, 1991 Opinion and Order. We agree. See Carol D. Goss, 43 Van Natta 2637 (1991).

The Referee reasoned that:

> "In Goss, the Board ordered that the insurer's appeal did not stay its duty to pay the award of permanent partial disability in a Determination Order. The Board in that case did not specifically address temporary time loss benefits awarded in a Determination Order but it is clear that its analysis would be the same." (Opinion at 2).

While we agree with the Referee's conclusions, we note that in Goss, we considered the stay of payment of both permanent partial and temporary total disability benefits under amended ORS 656.313. See Carol A. Goss, 43 Van Natta at 2638 & 2639.

SAIF argues that Goss is inapplicable to the present case in that in Goss, the insurer's request for Board review was filed prior to the effective date of amended ORS 656.313. In the present case, on the other hand, SAIF filed its request for Board review after amended ORS 656.313 became effective.

We disagree with SAIF's assertion. SAIF is correct that in Goss, the insurer filed its request for review prior to the effective date of amended ORS 656.313. We held that in order for a stay of compensation to be effective, the insurer must file a "qualifying" appeal on or after July 1, 1990. Our primary holding in Goss, however, was that in order for a stay of compensation to be lawful, the employer/insurer's appeal must be from the order that awards compensation, rather than from some other order that does not, regardless of the date of the filing of the appeal.

The Goss holding is directly applicable to the present case, wherein SAIF has filed a request for Board review from a May 3, 1991 Referee's Opinion and Order. That Opinion and Order, however, did

not award the compensation SAIF seeks to have stayed pending appeal. Rather, it was the August 15, 1991 Determination Order that awarded both temporary and permanent partial disability compensation. SAIF did not appeal that Determination Order, nor did it pay the compensation ordered therein. Under Goss, SAIF's failure to pay was unlawful.

We adopt the Referee's "Conclusions and Opinion" on the issue of penalties and attorney fees. See Carol D. Goss, supra at 2640.

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 Board review concerning the stay of compensation 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 issues, and the value of the interest involved. We note that claimant 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 January 8, 1992 is affirmed. For services on Board review concerning the stay of compensation issue, claimant's attorney is awarded an assessed fee of $800, payable by the SAIF Corporation.

August 12, 1992 Cite as 44 Van Natta 1615 (1992)

In the Matter of the Compensation of
DELINDA S. FRENCH-DAVIS, Claimant
WCB Case No. 91-10411
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Leahy's order which set aside its partial denial of claimant's medial collateral ligament injury of the left knee. On review, the issue is compensability.

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

The insurer argues on review that because claimant has a preexisting left knee condition dating back to 1981 and 1987, ORS 656.005(7)(a)(B) requires claimant to establish that the compensable injury of February 1991 is the major contributing cause of her disability or need for medical treatment related to her current medial collateral ligament condition. We disagree that ORS 656.005(7)(a)(B) is applicable to the present case.

ORS 656.005(7)(a)(B) provides that "[i]f 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). However, when there is no evidence that the preexisting condition combined with the compensable injury, ORS 656.005(7)(a)(B) is not applicable and a claimant need not establish that the compensable injury is and remains the major contributing cause of disability or need for medical treatment. Gary Stevens, 44 Van Natta 1178 (1992).

Claimant had previously injured her left knee in 1981, which was treated with casting and physical therapy for approximately 4 months, and again in 1987, when she was off work for two days to keep weight off her leg. (Tr. 10-12). However, there is no evidence that claimant's preexisting knee condition combined with the compensable injury. Claimant credibly testified that she had no problems

with her knee following the 1981 injury and the 1987 injury. After treatment was completed both times, she engaged in physical activities, including running and extensive walking, without pain or other difficulty. At the time of the compensable injury in February 1991, claimant's job required walking about 5-7 miles every day, which claimant performed without difficulty. (See generally Tr. 9-12, 17-18).

Likewise, we find no medical evidence that any preexisting knee condition combined with the February 1991 injury to cause or prolong disability or the need for treatment. Dr. Loch, claimant's treating orthopedist, explained the MRI findings in which the medial collateral ligament was visualized: "No evidence for significant swelling. This suggests that the medial collateral ligament injury that she sustained at this time is probably a grade I injury on top of an old grade II injury." (Ex. 12-1). However, neither Dr. Loch nor any other physician indicates that the two injuries combined to cause or prolong disability or the need for treatment, or that the old, grade II injury was a cause of claimant's current medial collateral ligament condition. Furthermore, claimant is not seeking to establish compensability of the old grade II medial collateral ligament injury; she contends only that the recent, grade I injury is compensable. Under these circumstances, we conclude that claimant need not establish that her compensable injury was the major contributing cause of her disability or need for treatment. Gary Stevens, supra; see also Bahman M. Nazari, 43 Van Natta 2368 (1991).

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 $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 November 25, 1991 is affirmed. Claimant's attorney is awarded $800 for services on Board review, to be paid by the insurer.

August 12, 1992 Cite as 44 Van Natta 1616 (1992)

In the Matter of the Compensation of
MERIDEE A. KAIEL, Claimant
and CULTURAL HOMESTAY INSTITUTE, Noncomplying Employer
WCB Case Nos. 91-03467, 90-12953 & 90-20519
ORDER ON REVIEW
Schwabe, et al., Attorneys
Wallace & Klor, Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Moller and Westerband.

The noncomplying employer requests review of that portion of Referee Hoguet's order that set aside the SAIF Corporation's denial, on its behalf, of claimant's right ring finger injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

Claimant's injury was incurred while she was engaged in activities primarily for her personal pleasure.

Claimant's injury did not occur in the course of her employment.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

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

Subjectivity

The Referee concluded that claimant was a subject worker. We agree.

The employer argues on review that claimant is not a subject worker because her contract with the employer indicates she is an independent contractor. However, the fact that the parties considered their relationship to be that of employer-independent contractor is not controlling. Woody v. Waibel, 276 Or 189, 198-199 (1976). While we consider the contract as an expression of the parties' intent, we do not find it dispositive. See Kathleen McQuiggin, 42 Van Natta 2708, 2709 (1990).

For purposes of the Workers' Compensation Act, the test for determining who is a subject worker is the employer's right to control the performance of the services. See ORS 656.005(13) and (28). That test requires an application of the traditional "right to control" analysis and a consideration of the "nature of the work." Woody v. Waibel, supra.

Following our de novo review of the record, we are unable to determine from the traditional right to control factors whether the employer's degree of control is sufficient to classify claimant as a subject worker. Consequently, we analyze claimant's status pursuant to the nature-of-the work considerations. These considerations are: (1) the character of claimant's work; (2) the skill required; (3) whether claimant's work involves a separate enterprise; (4) whether claimant's work is an integral part of the employer's business; (5) whether claimant's salary is sufficient to expect her to bear the risk of a work-related injury; and (6) whether the duration of claimant's work is sufficient to amount to a hiring. See Woody v. Waibel, supra.

Analyzing these considerations, we find that the character of claimant's work was to recruit host families for foreign students, assist in teaching English as a second language and to plan and supervise her students' educational and cultural activities. Claimant was not a licensed teacher and had no special skills. Moreover, the services she provided did not constitute a separate business or enterprise, but were an integral part of the employer's educational and cultural exchange business. Claimant worked full time during the students' stay and the employer continued to contract with her after the initial contract was completed. Thus, the duration of claimant's work is sufficient to amount to a hiring. Finally, claimant's rate of pay was $325 per week plus $50 per host family. We conclude that this rate of pay is insufficient to bear the risk of a work-related injury.

Accordingly, claimant was an employee and not an independent contractor at the time of her injury and is, therefore, subject to the Workers' Compensation Law.

Compensability

The Referee found that claimant's injury occurred in the course and scope of her employment. We disagree.

Subsequent to the Referee's order, we issued Michael W. Hardenbrook, 44 Van Natta 529 (1992), wherein we construed ORS 656.005(7)(b)(B) to require that a statutory exclusion analysis precede any unitary work-connection analysis. See Rogers v. SAIF, 289 Or 633 (1980); Mellis v. McEwen, Hanna, Gisvold, 74 Or 571, 575, rev den 300 Or 249 (1985). We reasoned that, while ORS 656.005(7) defines a "compensable injury" as an accidental injury arising out of and in the course of employment, it expressly

excludes any injury incurred while engaging in a recreational activity primarily for the worker's personal pleasure. ORS 656.005(7)(b)(B). Accordingly, we concluded that the statute automatically excludes, inter alia, recreational activities "primarily" for a worker's personal pleasure; therefore, we must first determine whether that exclusion applies before proceeding to the unitary work-connection analysis. ORS 656.005(7)(b)(B).

Here, claimant's injury occurred while she rode the bumper cars during an optional student activity. Therefore, our initial inquiry in determining whether claimant's injury arose out of and in the course of employment must concern why claimant was riding the bumper cars. At hearing, claimant testified that riding the bumper cars was an optional activity, that she rode them for "fun" and that she rode them three times and paid for the rides herself. (Tr. 63-64, 231-232). The employer testified that, while optional activities such as the bumper car rides are listed in the students' itinerary, they are not supported and, in fact, are discouraged by the employer. (Tr. 98, 152, 182; Ex. 1-6). The employer agreed with claimant that she was not required to participate in the bumper cars rides. (Tr. 252).

On review, claimant alleges that she was riding the bumper cars in order to supervise the students. However, we are persuaded by the employer's testimony that supervision was not claimant's purpose. Operating a bumper car would be an impediment to supervision, since claimant's attention must necessarily be focused on operating the vehicle. She could not ride a bumper car and supervise her students simultaneously. (Tr. 251-252, 258). We are also persuaded by claimant's testimony that she rode the bumper cars for "fun." Consequently, on these facts, we find that riding the bumper cars did not have a close work nexus and was performed "primarily" for claimant's own pleasure. See Michael W. Hardenbrook, supra.

Moreover, if we analyze claimant's injury under the unitary work-connection test, we are also persuaded that there was not a sufficient benefit to the employer to find a work connection between an injury occurring during this carnival ride and claimant's employment. See Jack K. Kyle, 42 Van Natta 10 (1990).

Accordingly, we find that claimant's right ring finger injury was incurred while she was engaging in activities primarily for her personal pleasure. This is the type of injury the legislature intended to exclude from the 1990 statutory definition of "compensable injury" when it modified subsection (b)(B) of ORS 656.005(7). Michael W. Hardenbrook, supra. As claimant's finger condition did not arise out of and in the course of her employment, we conclude that it is not compensable.

ORDER

The Referee's order dated June 27, 1991 is reversed. The SAIF Corporation's denial, on behalf of the noncomplying employer, of claimant's right ring finger injury claim is reinstated and upheld. The $6,375 assessed attorney fee awarded to claimant's counsel is reversed.

In the Matter of the Compensation of
JAMES W. JORDON, Claimant
Own Motion No. 92-0400M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable right and left knee injury. Claimant's aggravation rights expired on May 21, 1992. SAIF opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force.

The Board's own motion authority extends to claims for worsened conditions which arise after the expiration of aggravation rights. Juan F. Carrizales, 43 VAn Natta 2811, (1991); Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988).

Here, SAIF received a May 13, 1992 chart note from Dr. Kaesche on May 21, 1992. The chart note reported that claimant had "increasing pain in the left knee" with a "possible internal derangement torn medical meniscus." As a result, Dr. Kaesche recommended a MRI of the left knee and noted that claimant "may need to have his claim reopened." On May 20, 1992, SAIF received the MRI scan which was performed on May 15, 1992. The MRI revealed a,"Posterior horn medial meniscus tear, olique undersurface in nature." Dr. Kaesche interpreted the MRI as showing a medical meniscus tear in the left knee and recommended an arthroscopic surgical procedure. Finally, in a June 9, 1992 chart note, Dr. Kaesche indicated that he had notified SAIF of claimant's impending surgery on May 18, 1992.

We find that the evidence taken as a whole, establishes that claimant perfected a valid claim for aggravation before the expiration of his aggravation rights. See Juan F. Carrizales, 43 Van Natta 2811 (1991). Accordingly, we lack own motion jurisdiction to consider claimant's current request for claim reopening and temporary disability benefits. Instead, SAIF should process claimant's request as a claim for aggravation under ORS 656.273.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN L. LAW, Claimant
WCB Case Nos. 91-00219 & 90-20445
ORDER ON RECONSIDERATION
Aller & Morrison, Claimant Attorneys
Gail M. Gage (Saif), Defense Attorney
Scheminske & Lyons, Defense Attorneys

On June 16, 1992, we withdrew our June 4, 1992 Order on Review that had: (1) found Cigna Insurance responsible for claimant's low back condition; (2) awarded claimant a carrier-paid attorney fee under ORS 656.386(1), payable by the SAIF Corporation, for services rendered in prompting the rescission of the compensability portion of its denial prior to hearing; and (3) awarded claimant an attorney fee payable out of claimant's compensation under ORS 656.386(2) for claimant's counsel's services at hearing. We took this action to consider SAIF's contention that it was not responsible for an attorney fee award. Since our abatement order we have received responses from Cigna and claimant, as well as claimant's request that he also receive a carrier-paid attorney fee for his counsel's services at the responsibility hearing. Having reviewed the parties' respective positions, we proceed with our reconsideration.

In support of its contention, SAIF relies on the court's recent decision in Multnomah County School District v. Tigner, 113 Or App 405 (June 10, 1992), which reversed that portion of our order in Rual E. Tigner, 42 Van Natta 2643 (1990), that had awarded claimant a carrier-paid attorney fee under ORS 656.386(1) when an order designating a paying agent under ORS 656.307 had not issued and responsibility was the sole issue at hearing. In Tigner, three carriers denied responsibility for claimant's stress condition. Since one of the carriers also denied compensability, no order designating a paying agent under ORS 656.307 issued. Prior to the hearing, the parties agreed that the carrier which had denied compensability could be dismissed as a party. The remaining carriers agreed that the sole issue at hearing was responsibility. The Referee found that the earlier carrier was responsible and awarded a carrier-paid attorney fee under ORS 656.386(1) payable by that carrier. On review, we held that the later carrier was responsible for the claim, as well as the attorney fee award.

The Tigner court held that a claimant is entitled to a carrier-paid attorney fee under ORS 656.386(1) only if a carrier denies the claim for compensation. Relying on Mercer Industries v. Rose, 103 Or App 96, 98 (1991), rev den 311 Or 150 (1991), the court reasoned that if a carrier denies responsibility, but not compensability, it has not denied a claim for compensation. See Hunt v. Garrett Freightliners, 92 Or App 40 (1988). Inasmuch as the carriers in Tigner had only denied responsibility, the court concluded that the claimant was not entitled to a carrier-paid attorney fee for the responsibility hearing.

Relying on amended ORS 656.386(1), the claimant in Tigner contended that his attorney was entitled to a fee for being instrumental in obtaining compensation without a hearing. The court reasoned that the statute was inapplicable because a hearing before a referee had been held.

Claimant seeks to distinguish Tigner, arguing that none of the carriers who had participated in the hearing had denied compensability. Noting that SAIF had denied compensability and rescinded that portion of its denial at the commencement of the hearing, claimant argues that he is entitled to an attorney fee pursuant to ORS 656.386(1) because his counsel was instrumental in accomplishing the rescission of the compensability portion of SAIF's denial.

We acknowledge that, unlike Tigner, one of the carriers to this hearing (SAIF) had previously denied compensability. Thus, SAIF had denied a claim for compensation. Nevertheless, SAIF rescinded the compensability portion of its denial immediately prior to the hearing. Moreover, the carriers conceded that the claim was compensable and that responsibility was the only issue. See International Paper Company v. Riggs, 114 Or App 203 (1992) (where compensability was not conceded and could have been challenged at hearing, the claimant was entitled to a carrier-paid attorney fee for participation at hearing). As we found in our prior order, claimant's counsel was instrumental in obtaining compensation for claimant. However, as in Tigner, a hearing was held. As expressly concluded by the Tigner court, amended ORS 656.386(1) is inapplicable when a hearing before a Referee has been held.

In accordance with the Tigner holding, since a hearing was held in this case, we conclude that claimant is not entitled to an attorney fee award under amended ORS 656.386(1) for services devoted to the rescission of the compensability portion of SAIF's denial. We further hold that claimant is not entitled to a carrier-paid attorney fee for his counsel's participation at the hearing because compensability of the claim was conceded. See International Paper Co. v. Riggs, supra. Therefore, that portion of our order which awarded a $1,500 carrier-paid attorney fee is withdrawn.

Finally, claimant requests that we reconsider that portion of our order which declined to award claimant a carrier-paid attorney fee against Cigna for services at the hearing. As explained by the Tigner court, in the absence of a "307" order, claimant is not entitled to a carrier-paid attorney fee for a hearing concerning the issue of responsibility. In light of the Tigner reasoning, we adhere to our prior conclusion.

Accordingly, our June 4, 1992 order is withdrawn. On reconsideration, as modified and supplemented herein, we republish our June 4, 1992 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Members Kinsley and Gunn dissenting.

For the reasons set out in the dissent in the Order on Review dated June 4, 1992, we remain of the opinion that, in cases such as this where responsibility between employers or insurers is at issue and where Compliance has not issued an order designating a paying agent pursuant to ORS 656.307, claimant should be entitled to the award of an assessed attorney fee pursuant to ORS 656.386(1).

As pointed out in that dissent, where responsibility is at issue and where Compliance has issued an order designating a paying agent pursuant to ORS 656.307, a claimant is assured of receiving compensation and, therefore, an assessed attorney fee payable pursuant to ORS 656.386(1) is not available. See ORS 656.307 and OAR 436-60-180(2), (5), (12) and (13). An order designating a paying agent automatically causes the responsibility matter to go to arbitration and claimant is entitled to an assessed attorney fee pursuant to ORS 656.307(5).

However, in cases such as this, where Compliance has not issued an order designating a paying agent, claimant's right to receive compensation remains in doubt unless:

(1) claimant timely files requests for hearing regarding each denial (otherwise, the denials would become final and claimant would be entitled to no compensation);

(2) claimant prepares evidence submissions and/or monitors the evidence submitted by the employers/insurers to ensure that adequate evidence is admitted that would support the claim as against one or more of the employers/insurers (if the evidence submitted for hearing is inadequate to reverse one or more of the denials, the denials would be affirmed and claimant would be entitled to no compensation);

(3) claimant attends and participates in the hearing to ensure that the proper issues are raised (the insurers/employers are not precluded from raising issues of compensability at hearing since Compliance did not issue an order pursuant to ORS 656.307), to ensure that the proper evidence is admitted (so that one or more of the denials is not affirmed), and to ensure that the matter is not dismissed (failure of the party that requested the hearing to attend the hearing can result in dismissal, which would allow the denials to become final and claimant would be entitled to no compensation); and

(4) claimant continues to follow the case until a final order is issued that entitles claimant to the payment of benefits (claimant is entitled to no benefits until such order issues).

We do not find that the opinion in Multnomah County School District v. Tigner, supra, would deny an attorney fee under ORS 656.386(1) given the facts of this case. The opinion in Tigner does not discuss the actions enumerated above that a claimant and/or a claimant's attorney must perform in order to ensure entitlement to compensation in those cases where Compliance has not issued an order designating a paying agent. However, those actions were required in this case because Compliance did not issue an order and, therefore, claimant was not receiving compensation and had no right to receive compensation until all the actions enumerated above were completed. We further note that the opinion in Tigner relied on Mercer Industries v. Rose, 103 Or App 96 (1991), rev den 311 Or 150 (1991) and Hunt v. Garrett Freightliners, 92 Or App 40 (1988) for the proposition that fees under ORS 656.386(1) are not available when the employer/insurer denies responsibility. However, both Rose and Hunt were cases where Compliance had issued an order designating a paying agent entitling the claimants to the payment of compensation. In this case, there is no such order.

The opinion in Tigner also held that the provision in ORS 656.386(1), which allows for attorney fees when an issue is settled prehearing, would not allow claimant a fee in Tigner. However, that holding is inapplicable to this case. Here, claimant's attorney's services were necessary throughout the prehearing, hearing and posthearing stages of the case until an order was issued entitling claimant to payment of compensation. In this case, the prehearing "concession" of the compensability issue, without an order designating a paying agent, means nothing with regard to claimant's continuing obligations to complete the actions enumerated above in order to be entitled to payment of compensation. Therefore, the attorney fee for prehearing settlement is inapplicable with regard to the above actions required to ensure payment of compensation since there was no prehearing settlement of an issue in this case resulting in the payment of compensation to the claimant. In line with this reasoning, we disagree with the majority on this point and Board Member Kinsley withdraws the second paragraph of her opinion in the June 4, 1992 Order on Review which held otherwise.

Finally, we believe that the approach we take in this opinion promotes a more efficient use of our Hearings Division and of the parties' time. In the face of the majority's approach, in cases such as this where, by the time of hearing, all the employers/insurers have "conceded" compensability but not responsibility and, for whatever reason, Compliance has not issued an order designating a paying agent and, thus, has not referred the matter for arbitration, claimants will need to ask for a continuance of the hearing so that they, based on the employers/insurers concessions, can obtain an order from Compliance and get an arbitration docketed. Then the claimants can withdraw the request for hearing on the responsibility issue and proceed to arbitration where they are entitled to an assessed fee under ORS 656.307(5) regarding that issue. Our approach of recognizing that, without Compliance's order, a "concession" of compensability still requires a claimant to protect the right to payment of compensation, avoids the round about process above and reaches the same end point of awarding claimant an assessed attorney fee.

For the above reasons, we respectfully dissent.

Board Member Hooton dissenting.

SAIF Corporation requested reconsideration of our Order on Review in light of the decision of the Court of Appeals in Multnomah County School District v. Tigner, 113 Or App 405 (1992). Specifically SAIF contends that:

> "In the present case, a hearing was held. Therefore, the provision of ORS 656.386(1) allowing a fee when claimant's counsel is instrumental in obtaining compensation without a hearing is not applicable. Claimant is not entitled to a fee under that provision." (Motion for Abatement and Recon. p. 2).

Based upon that argument the majority has revised its earlier Order and declined to allow claimant's attorney an assessed fee for efforts in obtaining the rescission of SAIF's compensability denial prior to hearing. Because this decision eviscerates Senate Bill 540, I must dissent. In addition the court's decision in Tigner casts serious doubt upon the validity of the position taken in dissent in the original Board order in this matter. I reaffirm my previous position for the reasons specified below.

ASSESSED ATTORNEY FEES FOR RESCISSION OF COMPENSABILITY DENIAL

On April 17, 1990, then Board members Cushing and Brittingham set out to review and revise a twenty-five year practice in workers' compensation cases of allowing an assessed attorney fee to claimant's attorney for obtaining the rescission of a compensability denial prior to hearing. Despite the obvious and compelling argument that the failure of the legislature to correct the Board's long standing "misinterpretation" of ORS 656.386(1) probably indicated that there was no misinterpretation in fact, they concluded that claimant was not entitled to an attorney fee under ORS 656.386(1) for obtaining the rescission of a compensability denial prior to hearing. The SAIF Corporation was a party to that dispute and a beneficiary of the decision. Duane E. Jones, 42 Van Natta 875 (1990).

On May 15, 1991, the Board's Order on Review was upheld by the Court of Appeals. Jones v.. OSCI, 107 Or App 78 (1991). In his dissenting opinion Judge Rossman wrote as follows:

> ". . . I cannot agree with the majority's decision that the statute was intended to preclude attorney fees in cases where the claim is settled before the final curtain comes down on a complete hearing. That result is so foreign to considerations of fairness and the efficient administration of justice, within the realm of the Workers' Compensation Law, that I must dissent.
>
> ". . .
>
> "A claimant incurs attorney fees throughout the entire process and should be fully compensated when a claim is accepted. The proper focus in determining whether claimant is entitled to attorney fees is on whether he finally prevailed on the issue of compensation, not when he prevailed or in what setting . . ..
>
> "In view of the legislature's apparent policy, as expressed in ORS 656.386, that the employer, not the claimant, bear the cost of a claimant's legal representation when a claim is erroneously rejected and it proceeds to the hearing level, the Board's interpretation of the statute is erroneous as a matter of law. For more than 20 years, the Board interpreted the statute to permit attorney fees for services provided after a request for a hearing had been filed but before the hearing. See former OAR 438-15-030(1). The legislature did nothing to change the interpretation, and I see no reason suddenly to move the goalposts now." 107 Or App @ 82 - 84 (1991) (Emphasis in the original).

The Legislature apparently agreed. With great speed, and with virtually no dissent, the Legislature passed, and on June 19, 1991 the Governor signed into law, Senate Bill 540 which amended ORS 656.386(1) to include a provision which specifically permitted assessed attorney fees for services rendered in obtaining compensation prior to a hearing. That prompt action on the part of the legislature forced a reconsideration and reversal of the Court of Appeals May 15, 1991 decision. Jones v. OSCI, 108

Or App 230 (1991). "Fairness and the efficient administration of justice" had returned to the workers' compensation system, (on this one issue at least). The brief aberration of Duane E. Jones was dead.

SAIF Corporation, however, is unwilling to allow the corpse of Duane E. Jones to rest in peace. Now, one year after the legislature's prompt and concise reaffirmation of its consistent intent in ORS 656.386, SAIF asks the Board to resurrect Jones and apply its reasoning to deny assessed attorney fees in a similar circumstance.

With the memory of Jones so near at hand, one would expect that cooler and wiser heads would prevail, and SAIF's attempt would meet a swift and decisive rebuke. Unfortunately, the majority is again persuaded to breathe life into Jones' moldy carcass, and, for a time again, at least, it appears that claimant's must search elsewhere for "fairness, and the efficient administration of justice, in the realm of the Workers' Compensation Law."

Sound principles of legal reasoning do not support the present interpretation of the courts opinion in Tigner, as a brief review of that decision will demonstrate.

Multnomah County School Dist. v. Tigner, supra, originally involved three insurers in a responsibility dispute. EBI companies insured Multnomah County School Dist. through June 30, 1987. Liberty Northwest insured the District thereafter. In addition, at all material times Liberty Northwest insured Mount Hood Community College. Claimant was employed full time with Multnomah County and part time with Mt. Hood. With the development of his stress condition claimant filed claims with each employer and all three insurers. EBI and Liberty (Multnomah) denied responsibility only, with Liberty (Multnomah) requesting the designation of a paying agent. No order issued, however, because Liberty (Mt. Hood) denied responsibility and compensability.

At the time of hearing all parties agreed that Liberty (Mt. Hood) should be dismissed as a party. No action was taken on the denials issued on behalf of Mt. Hood Community College and those denials became final by operation of law with the dismissal of Mt. Hood from the proceedings. Thereafter, the only issue raised by the insurers remaining in the proceeding was responsibility. Under these circumstances the case is properly treated as though compensability had never been at issue.

The Board allowed assessed attorney fees under ORS 656.386(1). The court, in reversing, found that ORS 656.386(1) does not provide a basis for such an award where responsibility is the only issue. 113 Or App @ 408, 409.

In support of the attorney fee award claimant argued, in the alternative, that the award was proper because claimant's attorney was instrumental in obtaining compensation. This argument relates to the remaining responsibility issue and arises from the manner in which the legislature amended ORS 656.386(1) following the debacle in Duane E. Jones, supra.

In order to return to the status quo the legislature need only have deleted the words "in a hearing" from the phrase "[i]n 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." ORS 656.386(1). Instead the legislature added language providing an attorney fee whenever "an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held,...." It is arguable that this additional language created an entirely new classification of assessed fees. Because claimant's attorney was instrumental in resolving the responsibility issue, claimant argued an entitlement to assessed, rather than approved, attorney fees. The court rejected this argument noting that, in this case, a hearing was held. 113 Or App @ 409.

SAIF Corporation and the majority have taken this simple statement to mean that an award of attorney fees for the rescission of a compensability denial prior to a hearing can never be awarded where a hearing is subsequently held involving other issues. That reasoning would prevent an assessed fee where, for example, an insurer rescinded a denial prior to hearing but litigated the amount of temporary disability due in interim compensation prior to the rescission. That reasoning leads to the anomalous results noted by Judge Rossman at the conclusion of his dissent in Jones v. OSCI, supra.

> "I am also very much concerned about the policy implications of the majority's holding. It is likely to discourage claimants from seeking the pre-hearing rescission of claim denials, because attorney fees, if any, will be deducted from the award. Obtaining relief effectively exposes claimant to a penalty. There are also negative consequences on the employer's side: The majority's result will eliminate an important incentive for employers to investigate and accept meritorious claims promptly and carefully and forces claimants to incur unnecessary expenses that the responsible employers will not be required to reimburse. Beginning with this case, other than the penalties imposed for unreasonable denials, there no longer is a risk of incurring attorney fees for denying valid claims. I believe that that unfairly places the financial burden of error on claimants." 107 Or App 84 n.1.

Because SAIF denied compensability, and that denial was rescinded at the time of the hearing, claimant is entitled to an attorney fee pursuant to ORS 656.386 (1). The notion that that entitlement is curtailed because a hearing was subsequently conducted on another issue is patently absurd.

ENTITLEMENT TO ASSESSED FEES ON RESPONSIBILITY ISSUE

In Tigner the Court of Appeals quite clearly indicated that its interpretation of ORS 656.386(1) did not permit the award of assessed attorney fees when responsibility was the only issue and an order under ORS 656.307 had not issued. Because that opinion is binding precedent on the Board, I will apply it in every appropriate case. Since I am writing in the dissent, however, I take this opportunity to reassert the position taken in the original dissenting opinion in this case. John L. Law, 44 Van Natta 1091, 1096 (1992). That opinion is incorporated by reference as though fully set forth herein.

In Tigner the court, for the first time, indicates that its analysis of attorney fees in ORS 656.307 cases decided prior to the enactment of ORS 656.307(5), will control its reasoning on the availability of attorney fees in responsibility cases in which no .307 order has issued. That reasoning depends upon the assertion of the platitude that because responsibility is the only issue claimant entitlement to receive compensation is not at risk. For the reasons stated in my prior dissent, I continue to believe that the courts view of responsibility determination is incorrect and that its resolution of the attorney fee issue is, therefore, in error. I would urge the court, or the legislature, to reexamine the process of responsibility adjudication, including burden of proof, the consequences to claimant if he fails to request a hearing from a responsibility denial and the consequences to claimant if he fails to attend the hearing. The claimant's entitlement to compensation is inevitably at risk, and no number of repetitions of words asserting the contrary will change that.

As claimant notes in his response to SAIF's Motion for Reconsideration, "[t]he policy implications of the majority's decision [on the entitlement to assessed fees under ORS 656.386(1)] are disturbing since the employer and insurers in future cases will invariably deny responsibility secure in the knowledge that they will never be exposed to the risk to (sic) of having to pay claimant's attorney fees. While employers enjoy the sport of litigating responsibility, the claimant waits for payment of his back time loss while he courts his family's financial disaster. In this case over six months have passed since the date of the referee's opinion and over 18 months have passed since the issuance of the denials. After all this delay, Claimant must swallow the bitter pill of paying the cost of his attorney [out of compensation to which the court believes he has always been entitled]. Cigna pays nothing other than the time loss long overdue less the interest it has earned while its appeal languidly awaits disposition." Where are the guarantees protecting claimant's entitlement to receive compensation in this oft repeated scenario. I can find none.

In the Matter of the Compensation of
PAMELA J. PANEK, Claimant
WCB Case No. 91-11126
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Moller.

The SAIF Corporation requests review of Referee Podnar's order that: (1) found that claimant's home health care program was reasonable and necessary; and (2) awarded an assessed attorney fee of $5,000. In her brief, claimant contends that the Referee had jurisdiction over the issue of unpaid medical services bills. On review, the issues are jurisdiction and attorney fees. We vacate in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of the last two sentences in that section.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

Home health care program

The Referee concluded that claimant's home health care, as prescribed by Dr. Friedman, was reasonable and necessary. Accordingly, he directed SAIF to provide claimant with such care five days per week.

On review, SAIF contends that claimant's health care consists primarily of assistance with housekeeping tasks such as cleaning and cooking. SAIF argues that the record consistently defines claimant's aide as a "housekeeper," and because we have previously found that such services do not fall within the definition of "medical services," claimant's health care is not compensable. See e.g. Lorenzen v. SAIF, 79 Or App 751 (1986); Maxine V. McInnis, 42 Van Natta 81 (1990).

Claimant argues that SAIF has misrepresented the health care services that have been provided to her. Claimant contends that the services are part of her treatment and consist of a visiting nurse or aide who monitors her medications, makes sure that she attends medical appointments and prepares her meals according to a prescribed diet. Finally, claimant argues that her home health care is necessary because, as the Referee found, her family's abusive behavior has contributed in the past to her psychological problems. Claimant, therefore, contends that the home health care enables her to avoid relying upon her family for such assistance.

We do not address the merits of the parties' arguments, as we find that we do not have jurisdiction over this matter.

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]."

In Mark L. Hadley, 44 Van Natta 690 (1992), the parties' dispute involved claimant's claim for use of a vehicle equipped with an automatic transmission. We concluded that, for purposes of applying ORS 656.327(1) and 656.704(3), the terms "medical treatment" and "medical services" have identical meanings. Consequently, in Hadley, we concluded that the medical services issue was not a dispute involving a "matter concerning a claim" over which the Hearings Division has original jurisdiction.

In the present case, the parties do not disagree over the issue of whether claimant's treatment is related to the compensable condition. Rather, the parties disagree over whether the type of home health care prescribed by claimant's doctor constitutes medical services.

We believe that this dispute involving services prescribed by claimant's treating physician lies within those matters the legislature intended to be resolved by a physician, rather than a referee. Accordingly, because a proceeding for resolving this issue is otherwise provided in ORS 656.327, we hold that original jurisdiction lies exclusively with the Director. See e.g. Gladys M. Theodore, 44 Van Natta 905 (1992) (jurisdiction over the issue of whether medical treatment is palliative rests exclusively with the Director).

We vacate the Referee's decision insofar as it purports to order SAIF to provide home health care services to claimant. We also vacate the Referee's attorney fee award for prevailing on the issue of home health care treatment.

Reimbursement of medical fees

We affirm the Referee on the issue of reimbursement for claimant's treatment team, and we adopt his "Conclusions" on that issue.

ORDER

The Referee's order dated November 27, 1991, as reconsidered by the December 20, 1991 order, is vacated in part and affirmed in part. That portion of the Referee's order that directed the SAIF Corporation to provide claimant's home health care services is vacated. Claimant's request for hearing regarding that issue is dismissed for lack of jurisdiction. The Referee's assessed attorney fee is also reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
JOSEPH S. SPEAKS, Claimant
WCB Case Nos. 90-05680, 89-14412 & 90-05505
ORDER ON REVIEW
Robert L. Philmon, Claimant Attorney
C. David Hall, Defense Attorney
Douglas Oliver (Saif), Defense Attorney
Schultz & Taylor, Defense Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

The noncomplying employer (Custom Enclosures) requests review of that portion of Referee Seifert's order that: (1) set aside the SAIF Corporation's "new injury" denial (on behalf of Custom Enclosures) of claimant's claim for his right shoulder condition; (2) upheld Liberty Northwest Insurance Corporation's denial (on behalf of Washington County Fence Company) of claimant's aggravation claim for the same condition; and (3) upheld Liberty Northwest Insurance Corporation's denial (on behalf of Brod & McClung) of claimant's "new injury" 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

At the outset, we note that the present case involves a request for review filed by the noncomplying employer, rather than by SAIF, which had denied the claim on its behalf. However, 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 of compensability and responsibility, 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); Bryan E. Mitchell, 44 Van Natta 1270 (1992).

Here, the Referee cited case law prior to the 1990 amendments and found that claimant's work activities with the noncomplying employer independently contributed to the worsening of claimant's accepted right shoulder condition. The Referee further found no contribution by claimant's work activity with the subsequent employer, Brod & McClung. Accordingly, the Referee concluded that SAIF, on behalf of Custom Enclosures, the noncomplying employer, was responsible for claimant's right shoulder condition. We agree with the Referee's conclusion, but we apply the following analysis.

Compensability

We adopt the Referee's reasoning on the issue of compensability of claimant's right shoulder condition.

Responsibility

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 pursuant to ORS 656.308(1), a carrier that is responsible for a compensable injury remains responsible for future compensable medical services and 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 1987 right shoulder injury, Washington County Fence Company remains responsible for any further medical services and disability unless it is due to a new compensable injury sustained during claimant's work for Custom Enclosures.

Here, we agree with the Referee that claimant's prior injury had resolved and the subsequent work activity with Custom Enclosures resulted in right shoulder problems and an increase in pain. Dr. Shephard, M.D., reported that claimant's condition had been worsened by his 1989 injury at Custom Enclosures. Additionally, Dr. Fuller, M.D., reported that claimant's acute tendonitis was attributable to his work with Custom Enclosures in June 1989.

Under the circumstances, we find that Washington County has established that claimant's work activity with Custom Enclosures, the noncomplying employer, was a material contributing cause of his right shoulder condition. Accordingly, Washington County has successfully proven a new compensable injury, and responsibility for claimant's right shoulder condition shifts to Custom Enclosures as a matter of law.

Finally, Custom Enclosures may, itself, shift responsibility to the subsequent employer, Brod & McClung, if it shows that claimant sustained a new injury during his work with Brod & McClung. However, the Referee found, and we agree, that claimant's work activities with Brod & McClung did not contribute to claimant's current problems. Under the circumstances, we find that Custom Enclosures has failed to prove that claimant sustained a new injury during his subsequent employment. Accordingly, responsibility remains with Custom Enclosures and SAIF Corporation.

We note that claimant would have been entitled to an attorney fee for prevailing against the employer's request for review. However, we are unable to award a fee in a case in which claimant has not submitted a brief on review. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated October 7, 1991 is affirmed.

In the Matter of the Compensation of
VIRGINIA L. POPE, Claimant
WCB Case No. 91-10943
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Hooton and Brazeau.

Claimant requests review of Referee Galton's order that: (1) affirmed a Determination Order award of no permanent partial disability; and (2) declined to assess a penalty for the insurer's allegedly unreasonable failure to pay compensation. On review, the issues are extent of unscheduled permanent disability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Permanent Partial Disability

Claimant seeks review of the Referee decision denying her request for an award of unscheduled permanent partial disability. She contends that she is entitled to an award of 2 percent impairment for loss of range of motion in the cervical spine, because the Medical Consultants Northwest reported that she had retained only 35 degrees of right lateral bending and 65 degrees of right cervical rotation.

We agree with claimant that, under the applicable standards, those range of motion findings would entitle her to an award of 2 percent impairment, provided that the disability is "due to" the compensable injury. ORS 656.214(5). We find no evidence, however, to establish that requisite causal relationship. In fact, the Medical Consultants Northwest noted that some of claimant's current complaints were related to her prior off-the-job motor vehicle accident and concluded: "We are not able to identify any permanent impairment, which we would have judged to be due to the November 5, 1990, injury, based on today's examination." (Ex. 11-5). Accordingly, we agree with the Referee that claimant is not entitled to an award of permanent disability.

Penalties

Claimant also challenges the Referee's failure to assess a penalty for the insurer's admitted failure to timely pay temporary disability benefits. The Referee concluded that no penalty was warranted, because there was no evidence that the delay was unreasonable.

ORS 656.262(10) provides that a penalty shall be assessed if an insurer "unreasonably delays or unreasonably refuses to pay compensation." In this case, the insurer offers no explanation for its failure to timely pay compensation. Absent some explanation, we conclude that the delay was unreasonable. Georgia Pacific v. Awmiller, 64 Or App 56 (1983). Accordingly, we conclude that the insurer's delay in paying temporary disability benefits constituted an unreasonable resistance to the payment of compensation under ORS 656.262(10), entitling claimant to a penalty equal to 25 percent of the amounts then due. Claimant's attorney shall receive one-half of the penalty, in lieu of an attorney fee. Nicolasa Martinez, 43 Van Natta 1638 (1991), aff'd Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

ORDER

The Referee's order dated November 18, 1991 is affirmed in part and reversed in part. For the insurer's unreasonable resistance to the payment of temporary disability compensation, claimant is awarded a penalty equal to 25 percent of the amounts of temporary disability due at the time of the insurer's delay, one half of which is payable to claimant's attorney in lieu of an attorney fee. The remainder of the order is affirmed.

In the Matter of the Compensation of
BARBARA A. SUPP, Claimant
WCB Case No. 91-05956
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

The self-insured employer requests review of those portions of Referee Michael Johnson's order which: (1) increased claimant's scheduled permanent disability for a bilateral forearm (wrist) condition from 7 percent (10.5 degrees) bilaterally, as awarded by an Order on Reconsideration, to 15 percent (22.5 degrees) for the left forearm (wrist) and 20 percent (30 degrees) for the right forearm (wrist); and (2) directed it to pay claimant's scheduled permanent partial disability award at the rate of $305 per degree. On review, the issues are extent and rate of scheduled permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Because claimant became medically stationary on July 27, 1990, and his claim was closed by Determination Order on August 22, 1990, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability (WCD Admin. Order 6-1988). Former OAR 436-35-110(3).

Extent of Scheduled Disability

The Referee relied upon the July 27, 1990 findings of Dr. Streitz as compared with the November 21, 1988 findings of Dr. Michels concerning grip strength to indicate a ratable loss. The Referee concluded that differences between the two indicated anatomical change. The employer argues that claimant's loss of grip strength is not ratable under the "standards" because there is no medical evidence establishing a loss due to nerve damage or anatomical change. See former OAR 436-35-110(3)(a) and (d).

The "standards" require that decreased grip strength be attributable to nerve damage, atrophy or other anatomical changes before a value can be assigned. Any finding of fact regarding the workers' impairment must be established by medical evidence that is supported by objective findings. ORS 656.283(7). Moreover, "magic words" are not required in a case in which the record, as a whole, satisfies claimant's burden of proof. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986).

Here, claimant was examined by Dr. Michels, chiropractor, on October 3, 1989. Dr. Michels reported: "Jamar dynomometer testing was as follows: Right 60 lbs., Left 60 lbs." (Ex. 1AA-2). On December 15, 1989, Dr. Streitz, claimant's treating surgeon, noted that claimant "relates she is consistently numb now in medial nerve distribution. She has been doing regular work but is gradually slower and notes decreased grip." (Ex. 1A-1).

On December 21, 1989 and January 8, 1990, Dr. Streitz performed carpal tunnel decompression with flexor tenosynovectomy on claimant's right and left wrist and hand, respectively. (Exs. 2, 3). Subsequently, on March 13, 1990, Dr. Streitz reported claimant's "[g]rip strength is 20 right and left hand." (Ex. 3A). On May 29, 1990, Dr. Streitz reported claimant's "[g]rip strength is 28 left and 35 right dominant hand. These are still down some from her preoperative status." (Ex. 3B). Finally, at claimant's closing examination, Dr. Streitz reported that claimant's "[g]rip strength is 42 right dominant and 35 left nondominant hand." (Ex. 4-1).

Based on the foregoing, we agree with the Referee and conclude that claimant is entitled to a 15 percent scheduled award for her right hand and a 20 percent scheduled award for her left.

Rate of Scheduled Disability

The Referee concluded that claimant's award of scheduled permanent disability should be paid at the rate of $305 per degree. The Referee relied on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), in which we held that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. Subsequent to the Referee's order, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992).

In this case, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury. ORS 656.202(2); Former ORS 656.214(2). Therefore, we reverse the Referee on the issue of rate of scheduled permanent disability.

Inasmuch as the employer has requested review and claimant's determination of scheduled disability has not been disallowed or reduced, claimant is entitled to a reasonable attorney fee award for that portion of the claim. 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 extent of scheduled permanent disability issue is $900, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 10, 1991 is affirmed in part and reversed in part. That portion of the Referee's order that directed the self-insured employer to pay claimant's scheduled permanent disability award at the rate of $305 per degree is reversed. For services on Board review on the issue of extent of scheduled permanent disability, claimant's counsel is entitled to an attorney fee award in the amount of $900, to be paid by the employer. The remainder of the order is affirmed.

In the Matter of the Compensation of
KATHI E. KOSLOW, Claimant
WCB Case No. 90-13909
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Hooton and Brazeau.

The insurer requests review of Referee Michael Johnson's order that: (1) set aside its denial of claimant's occupational disease claim for carpal tunnel syndrome; and (2) assessed a penalty for the insurer's unreasonable denial. On review, the issues are compensability and penalties.

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

In holding that claimant's carpal tunnel syndrome was compensable as an occupational disease, the Referee relied on the opinion of Dr. Jones, the treating physician. On review, the insurer contends that Jones' opinion is not probative, because it is based on an exclusion of possible causes.

A claimant cannot carry her burden of proof "merely by disproving other possible explanations of how the injury or disease occurred." ORS 656.266. The record reveals, however, that in addition to ruling out other potential causes of claimant's wrist condition, including a ganglion cyst or a compressive neuropathy, Jones considered claimant's medical history and work activities. Based on those considerations, he concluded that the major contributing cause of claimant's carpal tunnel syndrome was her repetitive work activities with the insured. Therefore, contrary to the insurer's allegation, Jones provides an affirmative causal link between claimant's work and her need for treatment. Based on that opinion, and in the absence of persuasive contrary evidence, we agree with the Referee that claimant has established a compensable claim.

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 $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 January 7, 1992 is affirmed. For services on Board review, claimant's attorney is entitled to an assessed fee of $850, to be paid by the insurer.

In the Matter of the Compensation of
RANDY S. LAY, Claimant
WCB Case No. 90-17841
ORDER ON REVIEW
Employers Defense Counsel, Claimant Attorneys

Reviewed by Board Members Brazeau and Hooton.

Claimant, pro se, requests review of Referee Herman's order which: (1) declined to grant claimant unscheduled permanent disability for his cervical condition; and (2) authorized Liberty Northwest Insurance Corporation to offset a $2,442.11 temporary total disability overpayment against any future permanent disability awards. Claimant also requests that we review a medical services issue. On review, the issues are extent of unscheduled permanent disability, medical services and offset.

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

In his request for Board review, claimant identifies the "payment of medical services related to his March 2, 1990 injury" as an issue. In our de novo review of the record, we find that claimant was unrepresented by counsel at the time the hearing was convened on January 15, 1991. Among the issues discussed at that time was claimant's entitlement to payment for certain chiropractic billings. (Tr. 2).

When hearing resumed on October 30, 1991, claimant was represented by counsel. His attorney, however, limited the issues to extent of disability and offset. (Tr. 1). The medical services issue was neither raised nor litigated at the continued hearing, and no evidence on the matter was submitted. We conclude, therefore, that the medical services issue was effectively withdrawn.

When an issue is not raised at hearing, that issue will not subsequently be considered on review. Mavis v. SAIF, 45 Or App 1059 (1980); Richard C. Centeno, 41 Van Natta 619, 620 (1989); Randy D. Johnson, 39 Van Natta 463, 465 (1987); Gunther H. Jacobi, 41 Van Natta 1031 (1989). We conclude that the same reasoning should apply to issues that are effectively withdrawn. Consequently, we decline to address the medical services issue raised on review. See Stevenson v. Blue Cross, 108 Or App 247 (1991).

ORDER

The Referee's order dated November 8, 1991 is affirmed.

In the Matter of the Compensation of
TIM A. FIDLER, Claimant
WCB Case No. 90-17133
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of those portions of Referee Bethlahmy's order that: (1) upheld the self-insured employer's denial of claimant's aggravation claim; and (2) declined to assess penalties and attorney fees for the employer's allegedly unreasonable denial. On review, the issues are aggravation, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

At hearing, the employer reiterated that the basis for its aggravation denial was insufficient evidence of a material worsening of claimant's underlying condition.

The last arrangement of compensation for claimant's neck and right shoulder condition was the October 24, 1989 Opinion and Order. The order did not contemplate future periods of waxing and waning of symptoms. When the order issued, claimant had been released and had returned to his usual and customary work.

On May 18, 1990, claimant experienced a symptomatic worsening of his neck and right shoulder condition, supported by objective medical findings. Claimant was taken off work completely.

Claimant's symptomatic worsening of his neck and right shoulder condition resulted in a diminished earning capacity below the level fixed at the time of the last arrangement of compensation.

Finding that claimant had failed to prove by medical evidence supported by objective findings that his underlying condition, "as distinguished from his symptoms," had worsened, the Referee upheld the employer's denial. We reverse.

CONCLUSIONS OF LAW AND OPINION

Aggravation

To establish an aggravation claim for an unscheduled condition, claimant must prove by a preponderance of the evidence that: (1) since the last arrangement of compensation, he has suffered a symptomatic or pathologic 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 accompanied by diminished earning capacity, claimant's diminished earning capacity exceeded that contemplated. ORS 656.273(1) and (8); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991); Leroy Frank, 43 Van Natta 1950 (1991). A worker need not prove a worsening of his underlying condition in order to establish a compensable aggravation. Jameson v. SAIF, 63 Or App 553 (1983). A symptomatic worsening, established by medical evidence supported by objective findings, is sufficient.

The employer argues that range of motion findings are insufficient to persuasively establish an objective worsening, because, while observable and somewhat objective, such findings are dependent on a claimant's voluntary participation. "Objective findings" in support of medical evidence are defined to include, but are not limited to, "ranges of motion, atrophy, muscle strength, muscle spasm, and diagnostic evidence substantiated by clinical findings." Amended ORS 656.005(19). A physician's report that he or she has examined claimant and determined that he suffers from a disability or physical condition that requires medical services satisfies this requirement. Georgia-Pacific Corp. v. Ferrer, 114 Or App 471 (1992); Suzanne Robertson, 43 Van Natta 1505 (1991).

On May 18, 1990, claimant experienced increased neck pain while leaning over to pick up an alternator. He was examined by Dr. Finseth, chiropractic physician, who has treated claimant over the course of the compensable July 1988 injury. Dr. Finseth noted claimant's subjective complaints, and recorded decreased cervical-thoracic spine ranges of motion as objective findings. In her January 9, 1991 narrative report, Dr. Finseth explained that because she is very familiar with claimant's condition, she recognized that his neck pain and restrictions on May 18 were not his "usual palliative presenting signs," but rather indicative of an aggravation.

Claimant next received care for his neck and shoulder condition at a Kaiser-Permanente facility, primarily from Dr. Twombly in the Industrial Medicine Clinic. Over the course of treatment, from May 28 through October 11, 1990, the Kaiser physicians noted restricted neck motion, and tenderness of the cervical paraspinal and trapezius muscles. Dr. Twombly uses workers' compensation legal terminology in less than a precise manner, for example, authorizing time loss while simultaneously reporting that claimant's condition is medically stationary, and that reopening of his claim is not indicated. Nevertheless, since claimant's initial visit, all Kaiser physicians have diagnosed an acute cervical strain as an aggravation of the July 1988 industrial injury. Thus, read as a whole, the findings as reported by both Dr. Finseth and the Kaiser physicians represent a symptomatic worsening supported by objective findings. Ferrer, supra; Suzanne Robertson, supra.

There is no dispute that claimant's symptomatic worsening resulted in diminished earning capacity below the level fixed at the time of the last arrangement of compensation. As of the October 1989 Opinion and Order, claimant had been released and had returned to his usual and customary work for the employer. As of May 18, 1990, claimant was unable to work, and time loss benefits were authorized.

The employer asserts that even if claimant's condition did worsen, Dr. Finseth's notation that claimant's May 1990 exacerbation was similar to one he experienced in May 1989 indicates that future periods of waxing and waning were contemplated by the October 1989 order. Thus, it contends, claimant's diminished earning capacity did not exceed that contemplated. We disagree.

The October 1989 order did not reference future flare-ups. Moreover, prior to the order, neither Dr. Finseth nor the Orthopedic Clinic predicted future waxing and waning of symptoms that would cause claimant to be disabled. The mere evidence of a past flare-up is not enough to establish that future flare-ups were contemplated where the order made no reference to the prognosis of the

claimant's neck and right shoulder condition, and, prior to the order, no doctor had predicted future flare-ups of the condition. Lucas v. Clark, supra. Moreover, although claimant could not do repetitive heavy work above shoulder level, as of the last arrangement of compensation, he was released to and did return to his usual and customary work for the employer. Claimant's May 18, 1990 acute cervical strain occurred while he was leaning over a trailer to pick up a small automotive part. Thus, claimant's symptomatic worsening was not caused by performing work for which he was permanently restricted at the time of the last arrangement of compensation.

In summary, we find that claimant has established a symptomatic worsening of his neck and right shoulder condition, supported by objective medical findings, since his last arrangement of compensation, which has resulted in diminished earning capacity below that fixed at the time of the last arrangement of compensation. Accordingly, claimant has established a compensable aggravation claim.

Finally, the employer argues that any worsening of claimant's condition is due to an injury which did not occur in the course and scope of claimant's employment. In this regard, a compensable worsening is generally established by proof that the compensable injury is a material contributing cause of the worsened condition. See Robert E. Leatherman, 43 Van Natta 1677 (1991). However, if there is an off-work injury that is the major contributing cause of the worsened condition, the worsening is not compensable. ORS 656.273(1); See Elizabeth A. Bonar-Hanson, 43 Van Natta 2578 (1991), aff'd mem Bonar-Hanson v. Aetna Casualty Co., 114 Or App 233 (1992).

We decline to address the employer's argument. The employer's written denial was based solely on the contention that there is insufficient objective evidence of a worsening of claimant's underlying condition since the last arrangement of compensation. Similarly, at hearing, the employer argued only that "there is insufficient evidence of a material worsening of claimant's underlying condition so as to constitute a compensable aggravation claim[.]" Given the different standard of proof arising from an alleged off-work injury situation, we conclude that claimant would be prejudiced were we to allow the employer to raise this defense on Board review. See Lisa M. Hawkins, 43 Van Natta 2779 (1991); Gunther H. Jacobi, 41 Van Natta 1031 (1989). Accordingly, we decline to consider the employer's argument.

Penalty

The Referee declined to assess a penalty for the employer's allegedly unreasonable denial. Although we have set aside the employer's denial, we agree that no penalty is warranted.

In determining if a denial is unreasonable, the question is whether the employer had a legitimate doubt as to its liability at the time of its denial. If the employer based its denial upon a legitimate doubt, the denial is not unreasonable. Brown v. Argonaut Co., 93 Or App 588 (1988). The employer's "reasonableness" and "legitimate doubt" must be evaluated in light of the information available to it at the time of the denial. Id.

Here, the only information received by the employer was from the Kaiser physicians. Dr. Finseth does not appear to have forwarded chart notes or a narrative report until six months after claimant's May 1990 injury. Although the Kaiser physicians authorized time loss, they also initially noted that claimant's condition was medically stationary, and that reopening of his claim was not indicated. Under these circumstances, we conclude that the employer had a legitimate doubt as to its liability for the claim. Accordingly, its denial was not unreasonable.

Attorney Fee at Hearing and on Board Review

Claimant's attorney is entitled to a reasonable assessed fee for services at hearing and on review relating to the aggravation issue. ORS 656.386. 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 self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the aggravation issue (as represented by the record at hearing and claimant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated July 3, 1991 is affirmed in part and reversed in part. The self-insured employer's denial is set aside, and the claim is remanded to the employer for processing in accordance with the law. The remainder of the order is affirmed. For services at hearing and on Board review concerning the aggravation issue, claimant's attorney is awarded an assessed attorney fee of $3,000, to be paid by the employer.

In the Matter of the Compensation of
DONNA M. MOORE, Claimant
WCB Case No. 91-05073
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Brazeau.

Claimant requests review of Referee Davis' order that: (1) found that medical services rendered to claimant's were "palliative"; and (2) granted the self-insured employer's motion to dismiss claimant's request for hearing. On review, the issue is jurisdiction. We vacate in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has a compensable back injury. In September 1990, he received treatment from Dr. Amsden, M.D., who filed a claim for aggravation on behalf of claimant in October 1990. In March 1991, the employer's denial of that aggravation claim was upheld by an Opinion and Order. After being advised by claimant's counsel of unpaid medical bills relating to claimant's treatment, the employer denied compensability of the medical treatment on the basis that it constituted palliative care. Claimant requested a hearing.

The Referee concluded that the treatment provided by Dr. Amsden was palliative. Additionally, because Dr. Amsden did not request approval for the treatment from the Director, the Referee found that the procedural requirements of ORS 656.245(1)(b), had not been satisfied and that the Hearings Division lacked jurisdiction to consider the matter. Therefore, the Referee granted the employer's motion to dismiss.

Claimant objects to the Referee's conclusion that he lacked jurisdiction. First, claimant contends that the employer is precluded by claim preclusion from denying the compensability of the treatment because, at the time it denied the claim for aggravation, it did not deny the compensability of the medical services. Claimant also argues that, notwithstanding our order in Stanley Meyers, 43 Van Natta 2643 (1991), the Referee had jurisdiction to consider the compensability of the medical services. Finally, claimant asserts that his rights under Article I, Sections 20 and 21 of the Oregon Constitution, as well as both the Fourteenth Amendment and Article I, Section 9 of the U.S. Constitution are violated by the pertinent statutes and administrative rules.

We first note that claimant neither raised his constitutional arguments nor his assertion regarding claim preclusion at the hearing before the Referee. We, therefore, decline to address either of those arguments on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991). Consequently, our order considers only the jurisdictional issue.

In Stanley Meyers, supra, 43 Van Natta at 2645, we construed ORS 656.327(1)(a) and (2), 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 [administrative] rules regarding the performance of medical services" exclusively with the Director.

More recently, we considered the issue of our jurisdiction to determine whether or not a claimant's medical treatment is palliative, thereby rendering such treatment 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 the characterization of medical treatment as palliative or curative generally concerns the effectiveness and appropriateness of such medical treatment. Id. at 908. Therefore, relying on Stanley Meyers, supra, we concluded that original jurisdiction of such a dispute lies exclusively with the Director under ORS 656.327. Id.

The present dispute involves whether or not the treatment rendered to claimant by Dr. Amsden, as well as a request for a customized chair, a radiologist's statement, and a physical therapy billing, constitute palliative or curative care. Based on our holding in Gladys M. Theodore, supra, we find that original jurisdiction over this dispute lies exclusively with the Director. The Referee thus lacked subject matter jurisdiction to determine that the disputed medical services 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 October 11, 1991 is vacated in part and affirmed in part. That portion of the order concluding that claimant's medical services constitute palliative care 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.

In the Matter of the Compensation of
MIGUEL M. OCHOA, Claimant
WCB Case No. 91-11824
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Schultz & Taylor, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee McCullough's order that increased his scheduled permanent disability award from 9 percent (13.5 degrees), as awarded by Determination Order, to 10 percent (15 degrees) scheduled permanent disability for loss of use or function of his right hand. On review, the issue is extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

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

On review, claimant contends that the Referee erred by not awarding impairment values for his chronic condition limiting the repetitive use of his right hand and for loss of opposition of the middle and ring fingers.

Chronic condition

Here, the Referee properly applied the standards in effect at the time of claim closure. Because claimant's claim was closed by a March 22, 1991 Determination Order, former OAR 436-35-010 through

436-35-360, as amended by temporary rules in effect at the time of closure, apply to the rating of claimant's scheduled permanent disability. WCD Admin. Orders 6-1988, 15-1990 and 20-1990. Accordingly, under the standards in effect at the time of claimant's claim closure, claimant is not entitled to a value for chronic condition as the impairment in this right hand exceeds 5 percent. See former OAR 436-35-010(8)(a).

Loss of opposition

Because the most beneficial method of calculating claimant's impairment is through former OAR 436-35-070 (converting finger losses to values for loss of use of the hand), claimant is not entitled to an additional rating for opposition, because the conversion chart for loss in the finger and thumb to loss in the hand already allows for loss of opposition. See former OAR 436-35-040(4); Barbara J. Glenzer, 42 Van Natta 1879 (1990). Accordingly, no additional rating is allowed for opposition.

ORDER

The Referee's order dated December 2, 1991 is affirmed.

August 17, 1992 Cite as 44 Van Natta 1637 (1992)

In the Matter of the Compensation of
B. D. SCHLEPP, Claimant
WCB Case No. 91-01166
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
VavRosky, MacColl, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Knapp's order that: (1) dismissed her hearing request for lack of jurisdiction; and (2) declined to assess penalties and attorney fees for failure to pay for palliative care. On review, the issues are jurisdiction, compensability of palliative treatment, penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. On January 11, 1991, the Director issued an order which found that claimant's palliative care was not necessary to enable her to continue current employment. Dr. Lee, treating physician, did not appeal this order. On January 25, 1991, claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

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. Or Laws 1990 (Special Session), ch. 2, § 54; see Ida M. Walker, 43 Van Natta 1402 (1991).

We reject claimant's argument that the application of the 1990 amendments to her claim is unconstitutional. See Hall v. Northwest Outward Bound School, 280 Or 655 (1977); Borisoff v. Workers' Compensation Board, 104 Or App 603 (1990); Ida M. Walker, supra.

Jurisdiction

On January 11, 1991, the Director issued an order finding that the requested palliative care was not necessary to enable claimant to continue her current employment. The Referee concluded that the Director's order had become final because administrative review of the order had not been requested.

On that basis, he concluded that the Hearings Division was without jurisdiction and dismissed claimant's request for hearing. We agree that the Hearings Division is without jurisdiction.

Subsequent to the Referee's order, we held that the Director has exclusive jurisdiction over palliative care issues that would otherwise not be compensable under one of the exceptions listed in ORS 656.245(1)(b). Rexi L. Nicholson, 44 Van Natta 1546 (1992). Here, claimant does not come within any of the exceptions that qualify palliative care as compensable. ORS 656.245(1)(b). The review process of a Director's order regarding these otherwise noncompensable palliative care issues includes an administrative review by right and a discretionary contested case hearing before the Director. Rexi L. Nicholson, supra. The statutory scheme does not include review of a Director's order regarding otherwise noncompensable palliative care issues by the Hearings Division or the Board. Id. Thus, if the present case involved solely the issue of the compensability of Dr. Lee's proposed acupuncture treatments as palliative care, there would be no question but that neither the Hearings Division nor the Board have jurisdiction. However, the issue here is complicated by the existence of a Stipulated Order that addresses treatment by Dr. Lee.

In August 1987, the parties entered into a Stipulated Order which provided, in part, that "claimant's treatment with Dr. Lee is allowed under ORS 656.245 provided the treatment remains reasonable and necessary, as related to the industrial injury." (Ex. 78-3). At hearing and on review, claimant argues that the reasonableness and necessity of the palliative care (acupuncture) is not at issue because the sole issue is the enforcement of the stipulation. However, the stipulation specifically states that the treatment with Dr. Lee is allowed only so long as it remains reasonable and necessary. Thus, in order to enforce the stipulation, the reasonableness and necessity of the palliative treatment must be determined.

We have held that, when a dispute solely concerns the meaning and appropriate application of a Stipulated Order's terms, the Hearings Division has jurisdiction to enforce the stipulation. Patrick E. Riley, 44 Van Natta 281 (1992). However, where the stipulation references statutes or administrative rules that invoke the Director's jurisdiction, claimant cannot invoke the jurisdiction of the Hearings Division before seeking administrative review by the Director. See Patrick E. Riley, supra; Kevin A. Haines, 43 Van Natta 1041 (1991).

Here, the stipulation incorporated ORS 656.245 by reference and added the further requirement that the treatments by Dr. Lee must be "reasonable and necessary, as related to the industrial injury." (Ex. 78-3). As noted above, the Director has exclusive jurisdiction over palliative care that is not compensable under one of the exceptions listed in ORS 656.245(1)(b).

We note that we find our recent decision in Louise A. Greiner, 44 Van Natta 527 (1992), to be distinguishable from the present case. In Greiner, we found that the dispute solely concerned the application of the terms of a stipulation even though the stipulation contained a reference to the "guidelines." Specifically, the employer did not challenge claimant's treatment as excessive or inappropriate under the guidelines, but instead defended its failure to comply with the terms of the stipulation on the ground that the new law first requires authorization for palliative care from the Director. Here, however, claimant lost before the Director and now contends that she is entitled to the treatment by the terms of the stipulation. The problem with that argument is that the stipulation, by its terms, authorizes the treatment so long as the treatment remains reasonable and necessary under ORS 656.245. Under the new law, that question is in the exclusive province of the Director. Rexi L. Nicholson, supra. Furthermore, the Director decided it against claimant.

Penalties and Attorney Fees

Because we have no jurisdiction over the compensability of the requested palliative care, we do not address the issue of penalties and attorney fees regarding any alleged unreasonable failure to pay for such palliative care.

ORDER

The Referee's order dated May 2, 1991 is affirmed.

In the Matter of the Compensation of
JAMES F. SHISSLER, Claimant
WCB Case No. 91-08517
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of Referee Leahy's order which: (1) set aside its "de facto" denial of claimant's medical services claim for separate living quarters; (2) assessed a penalty of 25 percent of the amounts made due by the Referee's order, to be shared equally by claimant and his attorney, pursuant to ORS 656.262(10); and (3) awarded claimant's counsel an assessed fee of $500 for the insurer's unreasonable "de facto" denial, pursuant to ORS 656.382(1). On review, the issues are jurisdiction, medical services, and penalties and related attorney fees. We vacate.

FINDINGS OF FACT

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

The first sentence in the paragraph under "Ultimate Findings of Fact" should read: "Claimant's present condition includes the diagnosis of "major mental illness." (emphasis added).

CONCLUSIONS OF LAW AND OPINION

On June 15, 1988 and again on January 22, 1991, claimant's treating psychiatrist, Dr. Berger, requested the insurer to provide claimant separate living quarters, in lieu of hospitalization, as part of the ongoing psychiatric treatment for his compensable head injury. (Exs. 34, 60A). Claimant contends that separate living quarters are a compensable medical service under ORS 656.245(1)(c). The insurer disagrees. The parties' disagreement focuses on whether the provision of separate living quarters is the type of medical service encompassed within the phrase "other related services" in ORS 656.245(1)(c). (See Tr. 6, 9; Exs. 61, 63). The Referee found the requested medical service to be compensable. We vacate the Referee's order 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 claimant requested a hearing after May 1, 1990 and 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 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, whether the dispute concerns current or proposed medical treatment, while jurisdiction over whether medical treatment is causally related to the compensable injury remains with the Board and its Hearings Division. Id.; Kevin S. Keller, 44 Van Natta 225 (1992); Michael A. Jaquay, 44 Van Natta 173 (1992). Recently, we held that the Director has jurisdiction over a dispute regarding whether use of a vehicle equipped with automatic transmission, for which claimant sought partial reimbursement as a claimed medical service, is "inappropriate" within the meaning of ORS 656.327(1). Mark L. Hadley, 44 Van Natta 690 (1992).

Here, the insurer contends that the provision of separate living quarters is not encompassed within the phrase "other related services" in ORS 656.245(1)(c), and therefore, its "de facto" denial should be upheld as a matter of law. At the hearing, the insurer did not contest the causal relationship of the requested medical service to claimant's compensable injury. (Tr. 6-7). Consequently, we hold that this dispute is within the Director's jurisdiction, since it pertains to the issue of whether the requested medical service is "excessive, inappropriate, ineffectual, or in violation of rules regarding

the performance of medical services." ORS 656.327(1); see also Mark Hadley, supra. We find there is no dispute concerning the causal relationship of the medical service to the compensable injury.

Accordingly, we hold that it is within the Director's jurisdiction to decide whether the requested medical service is of the type contemplated in ORS 656.245(1)(c), as well as whether it is reasonable and necessary. To have the matter considered, the insurer should request review by the Director pursuant to the Director's rules on the subject. ORS 656.327.

Consequently, we vacate the Referee's order which purported to set aside the insurer's "de facto" denial, award an attorney fee for prevailing against the denial, and assess a penalty and related attorney fees for the insurer's unreasonable conduct.

ORDER

The Referee's order dated December 5, 1991 is vacated. Claimant's hearing request is dismissed for lack of jurisdiction.

August 19, 1992 Cite as 44 Van Natta 1640 (1992)

In the Matter of the Compensation of
RODNEY L. DAVIS, Claimant
WCB Case Nos. 91-13455 & 91-06189
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Employers Defense Counsel, Defense Attorneys
Charles A. Ringo, Attorney

Reviewed by Board Members Neidig and Moller.

Liberty Northwest Insurance Corporation, on behalf of U & R Express, requests review of Referee Brown's order that: (1) set aside its denial of claimant's aggravation claim for a back condition; and (2) upheld its denial, on behalf of Gene Plunk Trucking, of claimant's "new injury" claim for the same condition. On review, the issues are responsibility and aggravation. We affirm.

FINDINGS OF FACT

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

Claimant's wage rate with U & R Express was higher than his wage rate at Gene Plunk Trucking. (Exs. 14 and 23).

CONCLUSIONS OF LAW AND OPINION

Responsibility

We first address U & R Express's argument that responsibility for claimant's condition shifts to Gene Plunk Trucking. In this regard, because claimant has an accepted compensable injury with U & R Express, resolution of the responsibility issue requires application of ORS 656.308. Under ORS 656.308(1), when 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 during the subsequent work exposure. Ricardo Vasquez, 43 Van Natta 1678, 1680 (1991). Here, the insurer, on behalf of U & R Express, asserts that responsibility shifts to the subsequent employer, Gene Plunk Trucking, on the basis that claimant sustained a "new compensable injury" while working for Gene Plunk Trucking.

U & R Express bases its contention on claimant's testimony that, in the course of driving a loaded truck to California for Gene Plunk Trucking, part of the tarp covering his load came loose, requiring him to tighten a strap. (Tr. 5-6). Claimant further testified that, while standing on the trailer

bed and pulling on the strap, he felt pain in his back and legs and slid down the load, landing on his feet on the ground. (Tr. 16-17).

Although the Referee, based on demeanor, found "no reason to doubt [claimant's] veracity," the Referee apparently disbelieved claimant's testimony regarding the strap incident based on both the fact that claimant's treating physician, Dr. Thomas, failed to record such an event and inconsistencies in claimant's testimony. We find that, whether or not claimant's account of the strap incident is credible, the medical evidence fails to support the occurrence of a "new compensable injury."

In his report, Dr. Thomas stated that claimant was driving truck and that his work duties included lifting heavy tarps onto loads and tying the tarps down with straps. (Ex. 21-1). As noted by the Referee, Dr. Thomas' report failed to mention any specific incident that resulted in an onset of pain. Based on this history and his examination, Dr. Thomas found that claimant had a "definite aggravation of his preexisting problems[.]" (Ex. 21-2). The Western Medical Consultants, who conducted an independent medical examination, did report that, while pulling on a strap, claimant twisted and fell to the ground. (Ex. 24-2). The Consultants "agreed with Dr. Thomas that the recent episode [of symptoms] would constitute an aggravation rather than a new injury" and concluded that the "pre-existing condition is the major cause of the need for current treatment." (Ex. 24-5).

Regardless of whether the medical evidence is based on a specific incident resulting in the onset of pain, it fails to prove that claimant's symptoms were due to an independent injury. Rather, the reports are in agreement that claimant experienced only an exacerbation of his previous injuries. Therefore, we conclude that there is no proof of a "new compensable injury" and that responsibility remains with U & R Express, the original employer.

Aggravation

U & R Express also contends that claimant failed to prove a compensable aggravation. In response, claimant asserts that U & R Express, because it denied only responsibility, may not contest compensability on review. We disagree.

At hearing, U & R Express limited its denial to responsibility. However, Gene Plunk Trucking denied responsibility and compensability. In such cases where compensability is denied, even though other carriers deny only responsibility, we have held that compensability remains at issue. See Rodney L. Kosta, 43 Van Natta 180 (1991). Furthermore, responsibility for a condition that is found to be noncompensable is not shifted to a carrier which denies only responsibility if compensability is raised by another carrier and the record is complete regarding the compensability issue. William L. Trunkey, 43 Van Natta 2749, 2751 (1991). Like Trunkey, compensability in this case was raised and evidence was presented on the issue. Therefore, we conclude that U & R Express is not prevented from contesting compensability on review.

In order to prove a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). A worsened condition is established with evidence of increased symptoms or a worsened condition resulting in diminished earning capacity. Leroy Frank, 43 Van Natta 1950 (1991). In addition, the worsening must be established with medical evidence supported by objective findings. ORS 656.273(1), (3). Finally, if the aggravation claim is submitted for an injury or disease for which permanent disability was awarded, claimant must prove that the worsening is more than waxing and waning of symptoms contemplated by the previous permanent disability award. ORS 656.273(8).

The medical evidence consists of reports from Dr. Thomas and the Western Medical Consultants. Dr. Thomas examined claimant the day after he left work with exacerbated symptoms. At that time, Dr. Dunn compared claimant's then-current condition with a physical examination of claimant two months prior to his own examination; Dr. Thomas found "more restricted lumbosacral flexion, range of motion, the positive straight leg raise on the right, and [positive] knee flexion testing in all directions[.]" (Ex. 21-2). Dr. Thomas also took claimant off work. (Id). The Western Medical Consultants found that claimant was "not yet medically stationary" and that his "current problem represents a symptomatic flare-up of his condition[.]" (Ex. 24-5). The report again emphasized that claimant's "condition has only been worsened symptomatically." (Id).

U & R Express contends that the report of Dr. Thomas is not reliable because it does not contain a reference to the April 23 strap incident and, therefore, is not based on a complete history. U & R Express also notes that Dr. Thomas later retracted his concurrence with the report of the Western Medical Consultants which, U & R Express asserts, shows that he lacks objectivity. U & R Express also argues that the report of the Western Medical Consultants is the more reliable evidence.

Again, we find that, whether we rely on the report of Dr. Thomas or that of the Western Medical Consultants, claimant proved a compensable aggravation. Dr. Thomas found that claimant had increased symptoms and physical findings demonstrating a worsened condition. Although the Western Medical Consultants did not agree with Dr. Thomas' physical findings, they concluded that claimant had experienced a symptomatic exacerbation of his condition and that there was no proof of secondary gain. Either report, therefore, supports a worsened condition supported by objective findings. See Leroy Frank, supra; Suzanne Robertson, 43 Van Natta 2762 (1991). Furthermore, Dr. Thomas took claimant off work; the Western Medical Consultants found that claimant was "not medically stationary" and stated that claimant probably would be limited from performing tarping and strapping on a permanent basis. Claimant's last arrangement of compensation contained no limitations on claimant's work duties. Therefore, under either report, claimant's worsened condition resulted in a diminished earning capacity. See Leroy Frank, supra.

Finally, we note that claimant's last arrangement of compensation, a stipulated agreement, provided claimant with a 24 percent unscheduled permanent partial disability award. Neither the agreement itself nor medical evidence dated before the agreement contains any referenece to anticipated future periods of waxing and waning of symptoms. Therefore, we find no basis for determining that claimant's worsening is a waxing and waning of symptoms contemplated by the last arrangement of compensation. See ORS 656.273(8); Lucas v. Clark, 106 Or App 687 (1991); Patricia V. Standard, 44 Van Natta 911 (1992) (no presumption that permanent disability award contemplates waxing and waning of symptoms).

Attorney Fee on Review

Claimant's right to compensation was at risk of disallowance or reduction on review. Therefore, claimant is entitled to a carrier-paid fee for services rendered on review. See ORS 656.382(2); 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 $1,200, to be paid by Liberty Northwest on behalf of U & R Express. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief and statement of services), the complexity of the issues, and the value to claimant of the interest involved.

ORDER

The Referee's order dated November 26, 1991 is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of $1,200, to be paid by Liberty Northwest Insurance Corporation, on behalf of U & R Express.

In the Matter of the Compensation of
ZODELLE L. HALBERG, Claimant
WCB Case No. 90-22039
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Brazeau and Moller.

Claimant requests review of Referee McWilliams' order that upheld the insurer's denial of claimant's request for authorization of proposed surgery for a knee condition. Claimant asserts that the denial is invalid because: (1) it was issued while the claim was in open status; or (2) the surgery is compensable either because the insurer accepted the conditions for which surgery was proposed in a stipulated agreement or such conditions are compensable under ORS 656.005(7)(a)(B). On review, the issues are procedural validity of the denial and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Procedural validity of denial

As she did at hearing, claimant argues that the insurer's denial is procedurally invalid because it was issued while the claim was in open status. Claimant cites to Roller v. Weyerhaeuser Co., 67 Or App 583, recon 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), and Guerrero v. Stayton Canning Co., 92 Or App 209 (1988), in support of her assertion. The Referee found Roller and the other cases inapplicable because the insurer's denial denied only the proposed request for surgery rather than an injury or condition. Furthermore, the Referee found the denial procedurally valid under Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989), because it denied only current, rather than future, medical treatment. We agree with and adopt that portion of the Referee's order with the following supplementation.

In Roller v. Weyerhaeuser Co., supra, the Court of Appeals addressed the validity of a denial disclaiming further responsibility for a diabetes condition that claimant had previously established was compensable. The claim had not yet been closed. The court found that allowing the employer to terminate future responsibility before the extent of claimant's disability had been determined was "tantamount to authorizing it to bypass a hearing on the extent of a claimant's disability and could preempt the resolution of an issue that is involved in determining the extent of disability." 67 Or App at 586. The court invalidated the denial on the basis that the employer could not summarily terminate time loss and medical benefits for claimant's compensable diabetes condition before claim closure. Id. at 587.

Subsequent cases have followed the doctrine provided in Roller, including Guerrero v. Stayton Canning Co., supra, where the court stated that "[a]n employer may not issue a partial denial of a previously accepted inseparable condition while the claim is still open." 92 Or App at 212. Moreover, despite questioning -- by the Supreme Court in Boise Cascade Corp. v. Katzenbach, 307 Or 391, 394 n 1 (1989) -- of the justification for the "Guerrero doctrine," the Court of Appeals recently applied the rule in Story v. Astoria Plywood Corp., 110 Or App 162, 164 (1991).

However, in Evanite Fiber Corp. v. Striplin, supra, the court limited the application of the "Guerrero doctrine" to denials of an injury or condition. For instance, the denial in Striplin denied "all further chiropractic care in that it is not reasonable, necessary, or attributable to [the claimant's] industrial injury[.]" The court found that the employer's and the Board's characterization of the denial as a "partial denial" was incorrect because the denial was limited to "all further chiropractic care" rather than an injury or condition. 99 Or App at 356. Therefore, the court found that it "need not reach the argument" whether the denial was invalid under Guerrero.

Furthermore, the court stated that, under ORS 656.245(1), 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 neccessary and attributable to the compensable injury." 92 Or App at 356-57. The court concluded that the denial was improper, however, because it attempted to deny future medical benefits. Id. at 357. Accord Green Thumb, Inc. v. Basl, 106 Or App 98 (1991) (court held that an employer can issue a denial either for a specific unpaid claim or for a current claimed need for treatment).

Here, although the claim was initially closed by a 1990 Determination Order, an October 1990 stipulated agreement "set aside in its entirety" the Determination Order. (Ex. 55). Consequently, the claim was in open status at the time the insurer issued its December 1990 denial. The denial stated that the insurer was "in receipt of medical information from your physician which indicates that you require papillar shaving and a lateral release for chondromalacia secondary to recurrent patellar subluxation." (Ex. 61-1). The letter further stated that, because the industrial injury "is not the major contributing factor to your current need for surgery, we must respectfully issue this partial denial of your proposed surgery and any medical costs and/or disability in connection with this surgery." (Id).

Claimant asserts that the denial is improper under Roller and Guerrero on the basis that claimant's treating physician explained that all of claimant's current knee conditions are inseparable and the physician treated those conditions as inseparable. Before addressing claimant's argument, however, we consider whether or not the insurer's letter actually qualifies as a "partial denial." See Evanite Fiber Corp. v. Striplin, supra. Although the insurer and claimant characterize the letter as a "partial denial," we agree with the Referee that, because the insurer did not specifically deny any injury or condition, the letter is not a "partial denial." See id.; Johnson v. Spectra Physics, 303 Or 49, 58 (1987). Rather, because the letter denied claimant's "current need for surgery," rather than the insurer's future responsibility for payment of benefits relating to the previously accepted claim, the denial was procedurally proper. See Green Thumb, Inc. v. Basl, supra.

Compensability

Next, claimant asserts that the conditions for which surgery was proposed are compensable. First, claimant contends that the employer accepted the conditions in the stipulated agreement. Alternatively, she argues that the conditions are compensable under ORS 656.005(7)(a)(B).

The insurer initially accepted a right knee strain that resulted from a February 1989 industrial injury. (Ex. 2). In March 1990, the claim was closed by Determination Order. (Ex. 32). After claimant continued to experience knee pain, she was examined by Dr. Kuller, orthopedic surgeon, who diagnosed "chondromalacia with marked patellar immobility." (Ex. 34). On July 26, 1990, Dr. Kuller reported that claimant had "stepped between two boxes" at work and "felt her knee snap." (Ex. 40). Claimant experienced a flareup of knee pain and swelling. (Id).

In August 1990, Dr. Kuller reported that claimant "continues to be severely symptomatic with respect to chondromalacia and patellar subluxation syndrome. A recent episode of subluxation has occurred and she has been off of work since that time." (Ex. 46). Dr. Kuller requested "authorization for arthroscopic surgery for patellar shaving and lateral release, to help her patella track properly, so that she will not continue to repetitively sublux." (Id). The following month, Dr. Kuller reported that claimant "did not seem to sustain a new injury to her right knee, but rather had an unrecognized problem of chondromalacia plus patellar subluxation at the time of [claim] closure" and that "her current treatment and need for surgery are attributable to her original injury, not a new injury, and I would term this a premature claim closure rather than an aggravation." (Ex. 51).

Claimant subsequently was examined by Dr. Baker, orthopedist, for an independent medical examination. In the history portion of his report, Dr. Baker stated that claimant "describes another 'popping' episode which occurred on July 20, 1990, which has exacerbated her leg pain." (Ex. 54-2).

In October 1990, as stated above, the parties entered into a stipulated agreement. The agreement stated that "Claimant filed a new claim for injuries to the same body part alleging injury in August of 1990 while in the course and scope of her duties with the same employer. The Claimant now agrees that the incident of August 1990 was merely an exacerbation of her previously accepted claim."

(Ex. 55-1). The stipulation further stated that "Claimant withdraws her claim for new injury arising out of an incident in August 1990 and the parties expressly agree and stipulate that any incident which may have occurred in August 1990 was merely an exacerbation of her previously accepted condition." (Id. at 1-2).

Claimant asserts that a "fair reading" of the stipulation "encompasses those conditions now requiring surgery," including chondromalacia and patellar subluxation syndrome. Claimant's argument largely depends on Dr. Kuller's opinion that such conditions were present and causing her symptoms since the February 1989 injury.

We find no evidence to support claimant's assertion that the insurer intended to accept claimant's current condition. Along with an agreement to set aside the Determination Order, the stipulation addresses claimant's "new injury claim" arising from an alleged August 1990 work incident. By its terms, the stipulation is limited to an agreement that an August 1990 incident resulted in an exacerbation of the previously accepted condition. This conclusion is supported by evidence that claimant reported to Drs. Kuller and Baker that, on July 20, 1990, she experienced another "popping" episode that resulted in increased symptoms. (Exs. 40, 46, 54-2). Although the date of the episode does not correspond with the August 1990 stipulation date, we find that the dates are sufficiently proximate that it is reasonable to interpret the stipulation as referring to the July 20, 1990 incident.

In summary, we do not construe the stipulation as supporting claimant's argument that the insurer accepted the chondromalacia and patellar subluxation syndrome conditions by entering into the stipulation. Therefore, claimant's conditions did not become compensable by virtue of that stipulation.

Finally, claimant asserts that treatment of her chondromalacia and patellar subluxation syndrome is compensable under ORS 656.005(7)(a)(B). That statute provides that, if a compensable injury combines with a preexisting disease or condition, "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." Claimant again relies on the opinion of Dr. Kuller as supporting her assertion that her February 1989 compensable injury remains the major contributing cause of the need for treatment of her chrondromalacia and patellar subluxation syndrome.

As a result of his examination, Dr. Baker diagnosed "right knee patellar tracking syndrome" and found that, although a previous MRI showed no abnormalities, chondromalacia may have developed since the date of the MRI. (54-5). Dr. Baker concluded that the patellar tracking syndrome "is developmental in etiology and is not related to industrial injury." (Id). Dr. Kuller agreed with Dr. Baker's diagnosis but felt that claimant's "problem is work related." (Ex. 56).

In a second request for authorization for surgery, Dr. Kuller stated that she did "feel that the need for surgery is related to [claimant's] industrial injury of 2/26/89." (Ex. 60). Dr. Kuller reiterated this opinion in a subsequent letter, stating: "I do continue to feel as I have felt all along, that [claimant's] work at Orange Julius is a major contributing cause of her ongoing patellar pain. I do feel that the industrial injury of 2-26-89 caused her condition to become and remain symptomatic." (Ex. 62). Dr. Kuller's final report stated that claimant "has high riding patella and a maltracking problem of her patella which is an anatomic variant with which she was born. Nonetheless, she was asymptomatic prior to her industrial injury. Her industrial injury brought her to a point of having knee pain, which she denies having had previously." (Ex. 65).

A second independent medical examination was performed by Dr. Hazel, orthopedic surgeon. He diagnosed "patellar chondromalacia, right, secondary to a patellofemoral tracking malalignment" and "sprain, possible subluxation of the patella on one or more occasions." (Ex. 63-3). He found that "it is evident that the sprain/strain injuries she sustained at work are not the genesis of her patellar tracking malalignment syndrome, but are simply expressions of that condition that are likely to occur under any circumstances." (Id). Dr. Hazel also agreed with Dr. Baker "that the cause of any additional surgery is related to her inherent configuration," including "any absence of antiversion of her hips or significant valgus of the knee" as well as "her high-riding patellae." (Id. at 3-4). Finally, Dr. Hazel stated that claimant "may have progressive chondromalacia" "associated with the underlying mal-tracking configuration." (Id. at 4). Dr. Kuller concurred with Dr. Hazel's report. (Ex. 64).

In terms of weighing the persuasiveness of medical opinions, where an advantage is gained from expert external observation, we generally give greater weight to the conclusions of claimant's treating physician, unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). However, where resolution of a complex medical issue turns on expert analysis rather than expert external observation, we rely on the most well-reasoned opinions. Hammons v. Perini Corp., 43 Or App 299 (1979).

Here, the dispositive inquiry is whether claimant's compensable injury is and remains the major contributing cause of her need for treatment. Dr. Kuller did not commence treatment of claimant until approximately one-and-one-half years after her compensable injury. The only apparent basis for Dr. Kuller's opinion regarding causation is the fact that the compensable injury initially rendered claimant's preexisting condition symptomatic. Given these facts, it is not apparent that Dr. Kuller's opinion regarding causation is entitled to any special deference.

Moreover, we find Dr. Kuller's opinion less persuasive than those of the other physicians. Dr. Kuller has opined that claimant's need for treatment "is related to" the compensable injury and that claimant's work "is a major contributing cause" (emphasis supplied) of her pain. However, the issue is whether the compensable injury remains the major contributing cause of her need for treatment. Although magic words of causation are not required, in light of the conclusory nature of Dr. Kuller's opinion, as well as the well-reasoned opinions of Drs. Hazel and Baker, we conclude that Dr. Kuller's opinion is less persuasive.

Having concluded that Dr. Kuller's opinion is neither entitled to greater weight nor persuasive, conclude that claimant failed to prove that her compensable injury is the major contributing cause of her condition. Therefore, claimant's need for treatment of her chondromalacia and patellar maltracking syndrome is not compensable under ORS 656.005(7)(a)(B).

ORDER

The Referee's order dated April 8, 1991, as amended April 17, 1991 and reconsidered October 3, 1991, is affirmed.

In the Matter of the Compensation of
JANE MATHEY, Claimant
WCB Case No. 91-04567
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Mitchell, et al., Defense Attorneys

Reviewed by Board Members Moller and Brazeau.

The insurer requests review of those portions of Referee Livesley's order that: (1) set aside its denial of claimant's "carpal tunnel"; and (2) found claimant's occupational disease claim for hand numbness compensable. On review, the issues are scope of the denial and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Scope of denial

The insurer denied compensability of "carpal tunnel." The Referee found there was "no definitive diagnosis of carpal tunnel syndrome." However, the Referee found that claimant's bilateral hand numbness was compensable.

The insurer asserts that the Referee set aside its denial on the basis that he found no definitive diagnosis of carpal tunnel syndrome and, therefore, concluded that the denial was premature. Further, the insurer asserts that the medical evidence was sufficient to constitute a claim for carpal tunnel syndrome, entitling it to accept or deny such a condition. Finally, the insurer contends that its denial was limited to carpal tunnel syndrome and that it did not encompass claimant's hand symptoms and, therefore, the Referee improperly addressed the compensability of such symptoms.

First, we find no indication in the order that the Referee concluded that the insurer's denial was premature. Therefore, we do not address the insurer's contention that the denial was not premature; rather, we proceed to consider whether or not the denial encompassed claimant's hand numbness condition.

We agree with the insurer that a Referee is limited to addressing only those conditions that have been denied. See Pamela S. Cheney, 44 Van Natta 1137, 1139 (1992). If a condition is not encompassed by the denial, and claimant's appeal is limited to that denial, the Referee lacks authority to consider the compensability of such condition. Id. Here, because claimant's request for hearing is limited to the denial, she may challenge only those conditions encompassed therein.

At the time of the April 1990 denial, the medical record consisted of reports from claimant's treating chiropractor, Dr. Burns, from whom claimant sought treatment for numbness in her fingertips following the acceptance of a shoulder strain claim. In February 1990, Dr. Burns referred claimant for electrodiagnostic services, which revealed "mild peripheral nerve entrapments at the carpal tunnel and tunnel of Guyon." (Ex. 13-1). In May 1990, claimant was referred to Dr. Okamoto, chiropractic orthopedist, who diagnosed right hand carpal tunnel syndrome. (Ex. 16-3). Dr. Burns apparently agreed with that diagnosis, reporting that her therapy was directed towards "bilateral carpal tunnel." (Ex. 17-1).

The medical record, therefore, consisted of diagnoses of carpal tunnel syndrome from Drs. Burns and Okamoto and cumulative trauma disorder from Dr. Long. In each case, however, the physicians' examinations and diagnoses were directed solely towards claimant's symptom of hand numbness. There is no indication that when Drs. Burns and Okamoto diagnosed carpal tunnel syndrome, they were referring to a different hand condition or symptoms than that diagnosed as cumulative trauma disorder by Dr. Long. Therefore, we find that whether diagnosed as carpal tunnel syndrome or cumulative trauma disorder, claimant's treatment was for symptoms of hand numbness.

The denial itself stated:

> "Current information also indicates that your current need for treatment is due to degenerative disk disease, also neck strain and carpal tunnel. The degenerative disk disease and your neck strain and carpal tunnel is not related to the accepted shoulder sprain and did not occur during the course and scope of your employment with Winchell's Donut Houses." (Ex. 30-1).

In determining the scope of the denial, we find it significant that the insurer stated that claimant's "current need for treatment is due to degenerative disk disease, also neck strain and carpal tunnel," and then asserted that such conditions were noncompensable. From this language, we conclude that the insurer intended to deny all conditions for which claimant had sought treatment. As noted above, although carrying differing diagnoses, claimant's treatment was always for hand numbness. Therefore, we conclude that the denial's reference to "carpal tunnel" was a reference to claimant's hand symptoms, rather than to a particular diagnosed condition. Consequently, we conclude that the scope of the denial included claimant's hand numbness. The Referee, therefore, had authority to address compensibility of that condition.

Compensability

The medical evidence establishes that claimant's hand condition preexisted her employment with Winchell's Donuts. Therefore, in order to prove a compensable occupational disease, claimant must establish that her employment conditions were the major contributing cause of the worsening of her

hand condition, and prove such worsening with medical evidence supported by objective findings. See ORS 656.802(2).

The medical evidence regarding compensability includes an IME report from the Western Medical Consultants. The report notes claimant's complaints of finger numbness and suggests that the sensory pattern "may be related to mild sensory neuropathies." The report concludes, however, that "the findings are not suggestive of carpal tunnel syndrome." (Ex. 34-5). The report further concludes that claimant's history "would suggest a pre-existing condition, the symptoms of which are brought on by repetitive activities" and that claimant's work activities only aggravated the condition. (Id). Dr. Murphy concurred with the Consultants' report. (Ex. 36).

Dr. Long reported that based on claimant's history of previous hand symptoms, "she had median and ulnar lesions at the wrists and elbows prior to her working for Winchell's in mid 1989. These conditions thus pre-existed her employment at Winchell's, but were essentially asymptomatic from 1985 to mid 1989." (Ex. 39-2). Dr. Long also concluded that claimant's work activities at Winchell's "did contribute to or worsen median lesions in the palms and ulnar lesions in the proximal forearms, caused her to develop symptoms of numbness and weakness, caused functional impairments, and contributed to the need for evaluation and treatment." (Id). Drs. Burns and Okamoto also rendered opinions that claimant's work was the major contributing cause of a worsening of her hand condition.

We find the most reliable opinion to be that of Dr. Long, who offered a well-reasoned analysis based on a complete history. See id. His opinion strongly supports the compensability of claimant's claim, and we conclude that the claim is compensable.

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 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 issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value to claimant of the interest involved.

ORDER

The Referee's order dated August 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.

August 19, 1992 Cite as 44 Van Natta 1648 (1992)

In the Matter of the Compensation of
BILLIE J. PETERSON, Claimant
WCB Case Nos. 91-09147 & 91-08483
ORDER OF ABATEMENT
Westmoreland & Shebley, Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

On July 22, 1992, we reversed that portion of a Referee's order that SAIF to pay claimant's scheduled permanent disability award at the rate of $305 per degree. The parties have now submitted a stipulation which purports to resolve this issue.

In light of such circumstances, we withdraw our July 22, 1992 order so that we may review the parties' proposed agreement.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARIA O. SAMAYOA, Claimant
WCB Case No. 91-04436
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee McCullough's order that dismissed her request for hearing from a Palliative Care Order. On review, the issue is jurisdiction. We affirm in part and vacate in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the Referee's finding that "[t]he medical services prescribed by Dr. Goldberg for claimant since September 4, 1990 were palliative, not curative."

CONCLUSIONS OF LAW AND OPINION

After her condition became medically stationary in December 1989, claimant continued to receive weekly chiropractic treatments, as prescribed by her treating physician, Dr. Goldberg, M.D. In December 1990, the insurer notified Dr. Goldberg that it refused to approve the chiropractic treatment provided after September 4, 1990. Dr. Goldberg responded that claimant had returned to light duty desk work and that the weekly chiropractic treatments were necessary to keep her at work. The insurer continued to refuse approval of such medical services.

In February 1991, Dr. Goldberg requested that the Department of Insurance and Finance review the insurer's disapproval of the care that he had prescribed for claimant. On March 28, 1991, a "Palliative Care Order" issued, concluding that the chiropractic treatments were "not appropriately related to the worker's January 10, 1989 injury; that the diagnosis is uncertain and not supported by objective findings," and ordered that the insurer "is not required to provide reimbursement for the palliative care requested by Charles Goldberg, M.D. for [claimant]." (Ex. 41-1). Claimant requested a hearing from the Palliative Care Order.

The Referee dismissed claimant's request, concluding that he lacked jurisdiction to consider the Palliative Care Order. The Referee based his conclusion on the statutory scheme provided by ORS 656.245(1)(b) charging the Director to appoint a panel of physicians pursuant to ORS 656.327(3) to review a request submitted by the attending physician for approval of palliative care. The Referee further noted that the Director had promulgated administrative rules providing for administrative review of an order approving or disapproving treatment. The Referee found the statutes and administrative rules provided a procedure for resolving a medical treatment dispute, therefore placing exclusive jurisdiction of the compensability of palliative care with the director and not the Hearings Division. See ORS 656.283(2); 656.704(3).

We agree with the Referee's conclusion and analysis. Recently, in Rexi L. Nicholson, 44 Van Natta 1546 (1992), we held that the Board and Hearings Division lacked jurisdiction to review a Director's order issued in response to an attending physician's request for approval of palliative care because review of such matters rest exclusively with the Director. Like the Referee, we based this conclusion on the statutory scheme provided in ORS 656.245(1)(b) and 656.327(3), as well as legislative history concerning medical services in general and palliative care in particular. Based on Nicholson, therefore, we conclude that the Referee correctly dismissed claimant's request for hearing from the Palliative Care Order on the basis that he lacked jurisdiction.

Claimant also asserts that the medical evidence demonstrates that the chiropractic treatments provided to claimant were curative in nature rather than palliative. Because the care was curative, claimant contends that ORS 656.245(1)(b) is not applicable and that the Hearings Division and the Board have jurisdiction to consider whether or not the chiropractic treatments were reasonable and necessary. The Referee, although concluding that he lacked jurisdiction to consider the Palliative Care Order, found that the medical evidence proved that the chiropractic treatments were palliative.

We first note that we have previously held that a determination whether or not medical treatment is palliative or curative generally concerned the effectiveness and appropriateness of such medical treatment and, therefore, original jurisdiction of such a dispute rests exclusively with the Director under ORS 656.327. See Gladys M. Theodore, 44 Van Natta 905, 906-07 (1992). Here, the Director found that the chiropractic treatments were palliative in the Palliative Care Order. Having found above that we lack jurisdiction to consider the Palliative Care Order, we also lack authority to consider any of the order's findings, including its characterization of the medical care at issue. Therefore, we conclude that the Referee lacked jurisdiction to consider whether or not the medical evidence supported the Palliative Care Order's finding that the chiropractic treatments were palliative, and we vacate that portion of his order.

ORDER

The Referee's order dated October 23, 1991 is affirmed in part and vacated in part. That portion of the order finding that the chiropractic treatments were palliative in nature is vacated. The remainder of the order is affirmed.

In the Matter of the Compensation of
ANGELA WEEKS, Claimant
WCB Case No. 90-05888
ORDER ON REVIEW
Bottini, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Moller and Brazeau.

The self-insured employer requests review of Referee Hazelett's order that increased claimant's scheduled permanent disability award for loss of use or function of the right hand from 9 percent (13.50 degrees), as awarded by a Notice of Closure, which was affirmed by an Order on Reconsideration, to 13 percent (24.96 degrees) for loss of use or function of the right arm. On review, the issue is extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant, "by her credible testimony and the corroborating medical evidence of her attending physician, has established by objective medical evidence that she has a chronic impairment of her right elbow which is related to her industrial injury." The employer challenges this conclusion, asserting that the Referee inappropriately relied on claimant's testimony to find that she had proved chronic condition impairment. The employer further asserts that the medical evidence alone does not establish such impairment.

We agree with employer that claimant's testimony, although probative, is insufficient to establish a chronic condition impairment. Without corroborating medical evidence, claimant is not entitled to an award for a chronic condition. ORS 656.283(7) requires that "[a]ny finding of fact regarding the worker's impairment must be established by medical evidence supported by objective findings." Furthermore, "findings regarding the worker's impairment for the purpose of evaluating the worker's disability" can be made only by the attending physician. ORS 656.245(3)(b)(B). We find these statutes to evidence the legislature's intent that a claimant's entitlement to permanent disability be proved by medical opinion.

This conclusion is further supported by the applicable disability rating standards. Former OAR 436-35-010(6) 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[.]" (Emphasis supplied). "Preponderance of medical opinion" "means the more probative and more reliable medical opinion based upon the most accurate history, on the most objective findings, on sound medical principles and expressed with clear and concise reasoning." Former OAR 436-35-005(10).

Like the statutes, the standards also express the requirement that impairment be established with medical opinion. Although a claimant's testimony may be probative, such as corroborating whether or not the medical opinions contain an accurate history, there is no entitlement to disability without supporting medical evidence. See Ruben D. Carlos, 43 Van Natta 605, 607 (1991). Therefore, we examine the medical evidence in this case to determine whether or not claimant has proved chronic condition impairment.

On May 1, 1991, claimant's attending physician, Dr. Hoppert, performed a closing examination. The report noted that claimant still had some weakness in the right hand when performing twisting functions and occasional numbness in a finger. (Ex. 29). Claimant's "biggest complaint is pain on the lateral aspect of the elbow, this comes and goes, seems to be the worst problem over the lateral epicondyle." (Id). Dr. Hoppert also stated that claimant "will continue her normal work, she needs no restrictions although I would recommend against any over head work, repetitive flexing or pulling with the arms." (Id).

We find the report sufficient to prove a chronic condition impairment in the right elbow. Although Dr. Hoppert stated that claimant needed no restrictions, he nevertheless recommended that she avoid overhead work as well as repetitive flexing or pulling with the arms. We are more persuaded by the physician's express limitations than by his more general statement regarding a lack of restrictions. Moreover, a release to normal work does not necessarily equate to an absence of loss of use or function. Here, for example, there is no evidence that claimant's employment as a grocery checker required overhead work. Accordingly, Dr. Hoppert's restriction from such use is not inconsistent with a release to normal work.

Claimant is entitled to a reasonable assessed attorney fee for her counsel's services on 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 $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 issue, and the value of the interest involved."

ORDER

The Referee's order dated December 30, 1991 is affirmed. For services on Board review, claimant's counsel is awarded a reasonable assessed attorney fee of $700, to be paid by the self-insured employer.

August 20, 1992 Cite as 44 Van Natta 1651 (1992)

In the Matter of the Compensation of
NEWT R. CHAPIN, Claimant
WCB Case No. 91-04972
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of that portion of Referee Brown's order that set aside its partial denial of claimant's claim for a current cervical/trapezius condition. Claimant cross-requests review of that portion of the order that upheld the employer's purported denial of "psychological factors affecting physical condition." On review, the issues is compensability. We affirm in part and vacate in part.

FINDINGS OF FACT

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

Claimant's January 22, 1991 work injury remains a material cause of her disability and need for treatment for a cervical/trapezial strain.

Claimant has not claimed disability or treatment for a psychological condition.

CONCLUSIONS OF LAW AND OPINION

Current cervical/trapezius condition

The employer accepted claimant's claim for a January 22, 1991 acute transitory musculoligamentous cervical/trapezial strain on April 18, 1991. (Ex. 23). The next day, it partially denied claimant's current condition, stating that the major contributing cause of claimant's current injury or disease "is not the accepted injury, but rather psychological factors affecting physical condition." (Ex. 25).

The Referee found that claimant suffers from a psychological condition which preexisted her upper torso injury and prolonged her recovery from that injury. He further found that the injury remains the major cause of claimant's current disability and need for treatment for a strain condition, under ORS 656.005(7)(a)(B). Although we agree that the injury-related condition remains compensable, we find ORS 656.005(7)(a)(B) to be inapplicable.

Due to the number of potential causes for claimant's current problems, the causation issue is a complex medical question. 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). In evaluating this evidence, we generally give great weight to the opinion of the treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983).

In this case, there are only two expert opinions concerning causation. Dr. Holland, psychiatrist, reviewed claimant's history, examined her once and diagnosed "psychological factors affecting physical condition." (Ex. 19). Based on claimant's prior history of stress-related upper torso complaints, Holland opined that this diagnosis could have been made prior to the injury. He found no difference between claimant's complaints before and after the January 22, 1991 injury and concluded that a preexisting psychological condition explains all or most of claimant's physical complaints. However, Holland also stated that he "would certainly implicate the role of stress in the perpetuation of [claimant's] symptoms." (Ex. 19-17).

Dr. Cordes, on the other hand, was claimant's treating physician before and after the January 1991 work injury. She did not believe that claimant has or had a psychiatric disorder or condition. However, she acknowledged a "strong psychological component" which impedes claimant's recovery from her work injury. Cordes explained that this psychological factor resulted from claimant's pain, her inability to work, and a "now very antagonistic job situtation." (Ex. 30-1). In addition, Cordes identified "repetitive tightening of the trapezius muscles. . .for a variety of reasons, including guarding and stress reaction" and "repetitive activity using arms and forearms" as causes of claimant's continuing need for treatment. (Exs. 30-3, 31). Cordes suspected that "re-injury" might be prolonging the course of claimant's recovery. (Ex. 17-2). She described claimant's tendency to shrug her shoulders in response to stress as a potential complicating factor and concluded that the repetitive tightening of trapezius muscles "has been the major contributing cause of [claimant's] continued injury since six weeks post the initial injury." (Ex. 30-3).

In evaluating the expert opinions, we acknowledge Holland's specialized expertise as a psychiatrist. However, Holland's opinion concerning claimant's pre-injury psychological status is not based on multiple first-hand observations, as Cordes' is. Moreover, considering Cordes' well-reasoned

opinion which is based on an accurate history, as well as repeated opportunities to observe and treat claimant, we find it appropriate to afford Cordes' opinion great weight. See Weiland v. SAIF, supra.

Based on Cordes' observations and reasoning, we conclude that claimant did not have a "preexisting condition," within the meaning of ORS 656.005(7)(a)(B). On the contrary, although Cordes acknowledged that psychological factors do contribute to the perpetuation of claimant's physical symptoms, the stress-related factors which she identified clearly arose post-injury. As such, they were not preexisting. Moreover, claimant's habitual tendency to shrug her shoulders in response to stress is not a preexisting "condition," as contemplated by ORS 656.005(7)(a)(B). It was clearly nothing more than a habit. For these reasons, we conclude that the insurer has not proven that claimant had a preexisting condition which combined with her compensable injury to cause or prolong her disability. Consequently, the limitations of ORS 656.005(7)(a)(B) are inapplicable and claimant need only prove that her compensable injury remains a material cause of her disability or need for treatment for her compensable injury. See ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). Based on Cordes' opinion, we further conclude, as did the Referee, that claimant has carried her burden of proving the compensability of her current cervical/trapezius condition.

Psychological factors affecting physical condition

In his order, the Referee affirmed the "[e]mployer's denial of psychological condition of 'psychological factors affecting physical condition.'" In part, claimant contends that the employer did not issue a denial of psychological conditions, and that therefore, the Referee reached an issue that was not before him. We agree. In relevant part, the denial states:

> "You filed a claim for a cervical/trapezius strain as captioned above. * * * [W]e accepted your claim and provided all benefits to you as required by Oregon law. We have recently received medical information that * * * you currently suffer from an injury or disease, the major contributing cause of which is not the accepted injury but rather, psychological factors affecting physical condition. We must therefore issue this partial denial of your claim for benefits for your current cervical/trapezial symptomology." (Ex. 25) (emphasis added).

Attorney Fee/Board Review

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 denial of claimant's current cervical/trapezius condition is $1,600, 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 statement of services and her 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 vacated in part and affirmed in part. That portion of the order that upheld the employer's purported denial of a psychological condition is vacated. The remainder of the order is affirmed. For services on review concerning the denial of claimant's current cervical/trapezius condition, claimant's attorney is awarded an assessed fee of $1,600, payable by the self-insured employer.

In the Matter of the Compensation of
TOR J. EAST, Claimant
WCB Case No. 91-06572
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Lipton's order that increased his unscheduled permanent disability award for a neck and shoulder injury from 8 percent (25.6 degrees), as awarded by an Order on Reconsideration, to 9 percent (28.8 degrees). In his brief, claimant objects to the Referee's exclusion of a medical report generated 2 months after the Order on Reconsideration. On review, the issues are evidence and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

Claimant has the residual physical capacity to perform work within the "medium" range.

CONCLUSIONS OF LAW AND OPINION

Evidence

Claimant contends that the Referee erred in refusing to admit proposed Exhibit 25, a July 17, 1991 note by Dr. Nelson, treating osteopath, concerning claimant's then-current work restrictions. We disagree.

Claimant's disability is rated as of the Order on Reconsideration pursuant to ORS 656.268. ORS 656.283(7). Here, the Order on Reconsideration issued on April 16, 1991. Because the proferred evidence pertains to claimant's disability two months after the Order on Reconsideration, it is not relevant to the rating of claimant's disability as of the Order. Consequently, we conclude that the Referee's decision to exclude proposed Exhibit 25 was within his discretion.

Extent of unscheduled permanent disability

The Referee applied the standards contained in WCD Admin. Order 2-1991, which was effective on April 1, 1991.

The rules in effect on the date of closure control the evaluation of claimant's permanent disability. In this case, the applicable rules are those in effect on December 6, 1990, the date the Determination Order issued. These are the rules which we apply.

Here, adaptability is the only disputed value under the standards. Because claimant has not returned to work and has not been offered employment within his restrictions, his adaptability value is determined under former OAR 465-35-310(4).

Claimant argues that, because the medical arbiter found his impairment measurements unreliable, we should "throw out" his opinion concerning claimant's residual physical capacity. However, inasmuch as the arbiter based his opinion regarding claimant's physical capacity on the nature of the injury and the MRI findings, not his impairment measurements, (see Ex. 22-4), this argument is not persuasive.

Claimant also contends that an April 6, 1990 Physical Capacities Evaluation (PCE) should be considered in evaluating claimant's adaptability. (See Ex. 8A). However, because the PCE was conducted eight months prior to claim closure, we are not persuaded that it reflects claimant's capacities at the time of claim closure. The only medical opinion concerning claimant's residual physical capacity at closure is that of the medical arbiter, who states that claimant is restricted to "medium" work. (Ex.

22-4). Based on that opinion, we conclude that the Order on Reconsideration correctly determined that claimant's adaptability value is +1 under former OAR 436-35-310(4).

Claimant also seeks a rating for his lack of formal training. However, because the standards in effect at the time of claim closure do not provide for such a rating, none is allowed.

Because the remaining values assigned by the Referee under the standards are neither disputed nor incorrectly calculated, we do not disturb them. Accordingly, claimant is entitled to a 9 percent unscheduled permanent partial disability award, as determined by the Referee.

ORDER

The Referee's order dated September 5, 1991, as reconsidered September 13, 1991, is affirmed.

August 20, 1992 Cite as 44 Van Natta 1655 (1992)

In the Matter of the Compensation of
GARY C. FISCHER, Claimant
WCB Case No. 91-08489
ORDER ON RECONSIDERATION
Hollis Ransom, Claimant Attorney
Charles Lundeen, Defense Attorney

Claimant requests reconsideration of our August 7, 1992 Order on Review. In that order, we found that the record was incompletely developed with regard to the issue of extent of scheduled permanent disability. We therefore remanded the matter to the Referee, and we noted that an exhibit that was generated after issuance of the Order on Reconsideration was not admissible pursuant to ORS 656.268.

On reconsideration, claimant contends that our evidentiary ruling is contrary to a recent Board case, Agnes C. Rusinovich, 44 Van Natta 1544 (1992). In Rusinovich, we held that, under the limited circumstances presented by the case, a report from a treating physician that was produced after claim closure constituted medical evidence that should have been but was not submitted by the physician serving as the attending physician at the time of claim closure. We concluded that the Referee properly received the report into evidence and used it for purposes of evaluating claimant's disability. Rusinovich, supra; ORS 656.268(5).

Rusinovich is distinguishable from the present case. In Rusinovich, the doctor's report was generated between the time of the Determination Order and the Order on Reconsideration. Such evidence, providing it meets the requirements of ORS 656.268(5), may be admitted into evidence to determine claimant's disability. However, in the present case, the report submitted by claimant was generated after the Order on Reconsideration had issued. Because ORS 656.268(5) requires subsequent corrective reports to be submitted "at the reconsideration proceeding," we do not find that the statute provides for the admission of the report submitted by claimant in the present case.

Accordingly, our August 7, 1992 Order on Review (Remanding) is withdrawn. As supplemented and clarified herein, we republish our August 7, 1992 Order on Review 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
DORTON H. NEWMAN, Claimant
WCB Case No. 91-11646
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Myers' order that upheld the insurer's denial of his low back injury claim. On review, the issues are subjectivity and, if claimant is an Oregon subject worker, compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the last sentence, with the following supplementation.

The employer first told claimant that he had been hired as a "consultant," rather than a permanent employee, pursuant to firing him after his July 1991 low back injury.

Claimant's out-of-state work for the employer was temporary and incidental to his Oregon employment.

A lifting incident at work in Kansas was a material cause of claimant's subsequent disability and need for treatment for his low back.

CONCLUSIONS OF LAW AND OPINION

The Referee decided that claimant was not an Oregon subject worker, largely because he found that claimant did not have a reasonable expectation of returning to work in Oregon after the low back injury which occurred in Kansas. We disagree.

In order to receive Oregon workers' compensation benefits for an injury sustained in another jurisdiction, a worker must be employed in Oregon and become injured while temporarily out of state incidental to the Oregon employment. ORS 656.126(1). In construing ORS 656.126(1), Oregon courts have applied a "permanent employment relation test." See Northwest Greentree, Inc. v. Cervantes-Ochoa, 113 Or 186 (1992). Under the test, the key inquiry is the extent to which claimant's work outside the state is temporary. In applying the test, 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 claimant's work assignment, the state laws and regulations that the employer is otherwise subject to and the residence of the employees. Id. (citing Power Master, Inc. v. Blanchard, 103 Or App 467, 471 (1990); Phelan v. H.S.C. Logging, Inc., 84 Or App 632, 635, rev den 303 Or 590 (1987)).

The employer is a Pennsylvania corporation, with its headquarters in Michigan. Claimant was originally hired on June 10, 1991, to work out of Sumner, Washington as Manager of Distribution. However, he began working in Oregon and received paychecks from the employer in Oregon, with Oregon state income taxes deducted. (Tr. 6, 16-17).

After a June 20, 1991 meeting, claimant's boss told him that the employer was negotiating a contract for an Oregon account and, if the account was secured, claimant would work in Oregon and handle that account. (Ex. 14-3-4). Claimant believed that the employer was "backing off" from the idea that he would work in Washington at that point. He later learned that the employer had decided not to replace its Washington manager, after all. (Tr. 19). Claimant never worked in Washington and the employer never asked him to relocate from Oregon, where he has lived for over 30 years. (Tr. 34).

During the short time that claimant worked for the employer, he travelled to California, Kansas and throughout Oregon, to learn the employer's business methods. (Ex. 14-2-5). During the month of July 1991, he made two work-related trips to Kansas, one for one week, the other for two weeks.

Between the trips, claimant returned home to Oregon. His work in Kansas was a temporary assignment only. (Tr. 12). While on the second trip, claimant injured his low back, lifting a battery which weighed approximately 130 pounds. After his injury, claimant returned to Oregon and sought medical treatment for his back. He continued working for the employer in Oregon until his doctor took him off work because of his low back condition on July 30, 1991.

From the outset, claimant understood that he was hired as a permanent salaried employee. (Ex. 14-2; Tr. 5). He was first informed that he was a "consultant," rather than a permanent employee on August 21, 1991, when he was fired "as of July 31, 1991." (Tr. 15-17).

In finding that claimant did not have a reasonable expectation of working in Oregon after the Kansas assignment, one of the factors that the Referee considered was that the employer did not obtain the Les Schwab account while claimant worked for the employer. The record does not establish what happened concerning the contract after claimant's brief period of employment. In any event, regardless of whether the contract was ever obtained, it is clear from the employer's own conduct that it considered the Les Schwab contract a serious business venture as it took specific actions to obtain it and to ensure that claimant acquired sufficient knowledge of the employer's operations to assume responsibility for it.

Claimant's testimony is unrebutted. His understanding regarding the nature and location of his work is uncontroverted and reasonable under these circumstances. On these facts, we find that claimant was employed as a permanent Oregon worker for the employer and that he was on a temporary out-of-state work assignment in July 1991 when he injured his low back. Consequently, claimant was an Oregon subject worker when he was injured. See ORS 656.126(1).

Claimant's description of his July 1991 injury at work is uncontroverted, as are the medical opinions relating his current low back problems to that injury. (See Exs. 6, 9A, 13, 14, 21, 23). On this evidence, we conclude that claimant has carried his burden of proving that his work injury was a material contributing cause of his subsequent disability and need for treatment for his low back. See ORS 656.005(7)(a); Mark N. Weidle, 43 Van Natta 855 (1991).

Claimant is entitled to an assessed attorney fee for prevailing on the compensability of his low back injury claim. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the injury claim is $1,500, 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 November 22, 1991 is reversed. The insurer's denial is set aside and the claim is remanded for processing according to law. For services at hearing and on Board review, claimant's counsel is awarded a reasonable attorney fee of $1,500, payable by the insurer.

In the Matter of the Compensation of
RONALD D. ROBINSON, Claimant
WCB Case No. 91-01531
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of those portions of Referee Fink's order that: (1) found that he is not entitled to temporary disability benefits from May 23, 1989 to January 9, 1990; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable resistance to the payment of compensation.

The insurer cross-requests review of that portion of the Referee's order that set aside its denial of claimant's request to change attending physicians. On review, the issues are temporary total disability and jurisdiction. We reverse in part and vacate in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Temporary disability

The Referee concluded that claimant was not entitled to temporary disability benefits because the doctor who authorized the benefits was not a licensed physician in the State of Oregon. On review, claimant contends that the law in effect prior to the 1990 amendments to the Act is applicable to his case because his temporary disability benefits were authorized in May 1989. Claimant contends that, at the time the temporary disability benefits were authorized, Drs. Tinker and Colistro qualified as attending physicians. Finally, claimant argues that a prior Referee directed the insurer to pay the benefits and the issue cannot be relitigated.

We agree with claimant that, in this case, the amendments to the 1990 Act do not apply to the issue of entitlement to temporary disability. The 1990 Act generally applies retroactively to existing claims, with the exception of those "saved" by litigation or provided for in other sections. Ida M. Walker, 43 Van Natta 1402 (1991). However, because the parties governed by the Workers' Compensation Law must conform their conduct to the law in effect at the time they act, it would be unfair to retroactively alter the rights and obligations of those who correctly relied upon the law in effect at the time of their actions. Id. Accordingly, in Walker, we concluded that the legislature did not intend the new law to be applied retroactively when such construction would produce an absurd or unjust result and would clearly be inconsistent with the purposes and policies of the Workers' Compensation Law.

In the present case, we conclude that it would be unfair to require claimant to comply with a law not yet in effect at the time he obtained authorization for temporary disability benefits. To hold otherwise would require claimant to have complied in May 1989, with a law that did not go into effect until July 1, 1990, which was six months after claimant had returned to work and any entitlement to temporary disability had ended. Under such circumstances, we conclude that retroactive application of the new law would be unreasonable and would result in prejudice to claimant. Accordingly, we conclude that the new law does not apply in the present case. See, e.g., Tammi L. Bryant, 43 Van Natta 1764 (1991).

The law in effect at the time claimant received authorization for temporary disability benefits provided that whether a claimant was entitled to such benefits depended upon whether a preponderance of the evidence indicated that claimant was disabled during that time due to the compensable claim. Botefur v. City of Creswell, 84 Or App 627 (1987). The law also provided that a doctor's verification of an inability to work was certainly evidence of disability, but was not necessarily the only relevant evidence. Garbutt v. SAIF, 297 Or 148 (1984); Kathy K. Mason, 43 Van Natta 679 (1991).

Accordingly, we conclude that, because the law in effect prior to the 1990 statutory amendments does not apply to this case, it is not relevant whether Dr. Tinker was licensed at the time he authorized claimant's temporary disability benefits. Moreover, we find that Dr. Tinker's May 23, 1989 case note, in addition to Dr. Colistro's report of May 26, 1989, establish that claimant was disabled during that time due to his compensable psychological condition. Therefore, we reverse the Referee and conclude that claimant has established entitlement to temporary disability benefits from May 23, 1989, until he returned to work on January 9, 1990.

Penalties and attorney fees

Claimant contends that he is entitled to penalties and attorney fees for the insurer's allegedly unreasonable resistance to the payment of compensation. We disagree.

At the time the prior Referee ordered the insurer to accept claimant's psychological condition and process it according to law, we find that the insurer had a legitimate doubt as to its liability for claimant's claim for temporary disability benefits. We agree that the insurer could have reasonably believed that the "new law" applied to claimant's entitlement to temporary disability benefits and that, under that law, Dr. Tinker did not qualify as an attending physician who was qualified to authorize such benefits. Accordingly, we affirm the Referee on the issue of penalties and attorney fees.

Jurisdiction/Change of attending physician

The Referee found, and we agree, that the 1990 Act applies to the issue of claimant's request for a change of attending physician. However, for that reason, we find that the Referee did not have jurisdiction to address the matter of whether claimant had changed physicians more than two times or whether the insurer had complied with the rule requiring it to inform claimant that any subsequent changes must be approved by the insurer or the Director. OAR 436-10-060(4); OAR 436-10-060(3)(c).

In Tracy Johnson, 43 Van Natta 2546 (1991), we concluded that we did not have jurisdiction over the issue of a dispute involving a claimant's request for a third change of attending physician. We found that such a dispute was, by definition, not a "matter concerning a claim" over which the Hearings Division has jurisdiction. Rather, we concluded that such disputes are solely within the province of the Director and must be resolved under the applicable procedures for administrative review set forth in former OAR 436-10-008(2). Johnson, supra; ORS 656.704(3); ORS 656.245(3).

Accordingly, in the present case, as in Johnson, we find that the statute provides a "proceeding for resolving a dispute regarding medical treatment," within the meaning of ORS 656.704(3). Consequently, because we find that original jurisdiction over this matter rests with the Director, rather than the Hearings Division, we vacate the portion of the Referee's order that purported to address the issue of change of attending physician. We also vacate the Referee's attorney fee award assessed in conjunction with that issue.

ORDER

The Referee's order dated May 21, 1991 is reversed in part and vacated in part. That portion of the Referee's order that declined to award temporary disability benefits is reversed. Claimant is awarded temporary total disability benefits for the period from May 23, 1989 to January 9, 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. The remainder of the Referee's order is vacated. The Referee's attorney fee award of $1,500 is also vacated. Claimant's request for hearing on the issue of change of treating physician is dismissed for lack of jurisdiction.

August 20, 1992 Cite as 44 Van Natta 1659 (1992)

In the Matter of the Compensation of
DEREK J. SCHWAGER, Claimant
WCB Case No. 90-19402
ORDER OF ABATEMENT
Olson, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Claimant requests reconsideration of our July 22, 1992 Order on Review. Specifically, claimant contends that we erred in concluding that his "new injury" claim was barred by res judicata. The SAIF Corporation's response has been received.

In order to allow sufficient time to consider the motion, the above noted order is withdrawn.

IT IS SO ORDERED.

In the Matter of the Compensation of
CINDY L. SMITH, Claimant
WCB Case No. 91-11406
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Neidig and Moller.

The insurer requests review of that portion of Referee Daughtry's order that assessed an attorney fee under ORS 656.382 for the insurer's allegedly unreasonable resistance to the payment of compensation. Alternatively, the insurer requests reduction of the $2,500 attorney fee. In her brief, claimant contends that the Referee should have awarded an assessed attorney fee pursuant to ORS 656.386. Claimant also asserts that she is entitled to a penalty for the insurer's allegedly unreasonable resistance to the payment of compensation. On review, the issue are penalties and attorney fees. We reverse.

FINDINGS OF FACT

Claimant suffered a right wrist injury on November 17, 1990. She filed a workers' compensation claim for a right wrist sprain which was accepted as nondisabling by the insurer on December 5, 1990.

Claimant subsequently reported right hand numbness since the date of her injury. Claimant was referred to Dr. Randall, neurologist, due to her continuing symptoms. Dr. Randall performed nerve conduction studies on January 2, 1991 which returned abnormal results. Dr. Randall initially diagnosed either bilateral carpal tunnel syndrome (although claimant was experiencing no left-sided symptoms) or a combination of carpal tunnel and pronator syndrome. He reported that such a diagnosis would be "consistent with [claimant's compensable] stretch injury." He further recommended that follow-up studies be performed in six to eight weeks. If her symptoms persisted, Dr. Randall opined that claimant should be examined for a possible polyneuropathy. (Ex. 7).

Claimant returned to Dr. Randall in March 1991 "to evaluate [her] previous stretch injury." Repeat nerve conduction studies disclosed continuing abnormality of the right ulnar nerve which, Dr. Randall reported, was "most likely again from a stretch injury." (Ex. 9).

Claimant signed an attorney retention agreement with her counsel on March 25, 1991.

Claimant was referred to Dr. Straub, orthopedic surgeon, for examination in April 1991. Although Dr. Straub was unsure of the etiology of claimant's right upper extremity symptoms, he reported that her nerve conduction studies were "more consistent with a polyneuropathy than any sort of a discreet [sic] lesion." He referred claimant back to Dr. Randall for a more complete neurological evaluation. (Ex. 11).

On April 18, 1991, the insurer reclassified claimant's claim as disabling and commenced payment of time loss.

Claimant again returned to Dr. Randall in May 1991 for further evaluation of her symptoms which she continued to relate to her November 17, 1990 injury. After additional examination of claimant, Dr. Randall reported:

> "My impression of [claimant] is that she does have evidence of both a right medial and ulnar nerve dysfunction in the forearm and wrist which may either be a neuropraxis secondary to a stretch injury in the forearm or perhaps even some type of compartment syndrome at the time of her swelling that caused a compressive injury to these nerves diffusely in the forearm. * * * [C]ertainly it is possible that she could have a diffuse polyneuropathy but certainly I do not see evidence of that on examination today." (Ex. 14)

Dr. Randall stated that he would have "his final impression" about claimant's condition following more studies.

Accordingly, claimant returned to Dr. Randall for yet additional electrodiagnostic studies later in May 1991. Dr. Randall opined that these additional studies were "most consistent with primarily a diffuse motor polyneuropathy." Dr. Randall further opined that this polyneuropathy condition was not related to claimant's work injury. Dr. Randall recommended further investigation of claimant's polyneuropathy condition, but claimant indicated that she did not wish to pursue any further evaluation of the condition. Dr. Randall referred claimant back to Dr. Straub for follow-up of her right wrist pain. (Ex. 15).

However, on referral, Dr. Straub indicated that he had no further treatment to offer claimant. He stated that he was "entrusting her care to Dr. Randall" because claimant "prefers to see him." He also released claimant to return to regular work. (Ex. 17).

On August 8, 1991, Dr. Randall again indicated that claimant had a diffuse polyneuropathy which was "independent" of her work injury. He also repeated that claimant declined further evaluation of her polyneuropathy condition. (Ex. 19).

On August 26, 1991, claimant's counsel filed a request for hearing with the Hearings Division, noting one of the issues as being a "de facto" denial.

Approximately one week later, on September 4, 1991, the insurer issued a written partial denial of claimant's polyneuropathy condition on the basis that it was not due to her work injury of November 17, 1990.

Claimant filed a supplemental hearing request from the written partial denial on September 12, 1991.

At hearing the Referee stated the issues as including "compensability with claimant contesting a partial denial of September 4, 1991." Counsel for both claimant and the insurer agreed with the Referee's statement of the issues. (Tr. 1).

CONCLUSIONS OF LAW AND OPINION

The Referee determined that the insurer's denial was premature since the polyneuropathy had been diagnosed, but no treatment had been provided. Reasoning that no polyneuropathy claim had been filed, the Referee set aside the denial. Furthermore, the Referee found that the insurer's denial constituted an unreasonable resistance to the payment of compensation. Consequently, the Referee awarded a $2,500 insurer-paid attorney fee pursuant to ORS 656.382. We reverse.

Where no "claim" for compensation has been made by the claimant or someone on the claimant's behalf pursuant to ORS 656.005(6), the issuance of a denial is considered to be premature. See Dorothy M. Jackson-Duncan, 42 Van Natta 1122 (1990). Nevertheless, when a treating physician is investigating an unrelated condition coincidentally with the treatment of an accepted condition, the issuance of a "precautionary" denial is appropriate. See Sidney M. Brooks, 38 Van Natta 925, 926 (1986).

Here, Dr. Randall, neurologist, was not claimant's treating physician. Rather, Randall examined claimant on referral from Dr. Straub, claimant's treating orthopedist. In May 1991, while evaluating claimant's wrist pain, Dr. Randall recommended further investigation of a diagnosed polyneuropathy condition. When claimant declined to pursue additional evaluation of the polyneuropathy condition, Dr. Randall returned her to Dr. Straub for treatment. In August 1991, after Dr. Straub recommended that claimant return to the care of Dr. Randall and to regular work, Dr. Randall reported that the diffuse polyneuropathy condition was "independent" of claimant's November 1990 compensable right wrist injury.

Such circumstances do not suggest that claimant was initially seeking compensation (medical treatment or disability benefits) for her polyneuropathy condition as related to her November 1990 compensable injury. Nonetheless, on August 26, 1991, through her attorney, claimant filed a hearing request concerning (among other issues) the insurer's "de facto" denial. Thereafter, the insurer issued a partial denial of claimant's polyneuropathy condition. At hearing, claimant did not withdraw her prior

contention that her claim had been "de facto" denied. Instead, her counsel agreed with the Referee's statement that compensability of claimant's polyneuropathy condition was an issue for resolution.

We have previously held that, if the claimant contends that in fact she is not making a claim for denied conditions, we will set aside the denial as ineffective until such time as the claimant actually makes a claim for such conditions. Dorothy M. Jackson-Duncan, supra. However, even if a denial could be challenged as premature, litigation of the merits of a condition at hearing serves as a waiver of any potential procedural defect. Id.

Applying the Jackson-Duncan rationale, we conclude that any possible challenge to the insurer's denial was waived by claimant's failure to withdraw her hearing request regarding a "de facto" denial and her agreement with the Referee's statement that compensability of the polyneuropathy condition was an issue at hearing. Consequently, we hold that the compensability issue was ripe for adjudication. Inasmuch as Dr. Randall has unequivocally opined that the polyneuropathy condition is unrelated to claimant's compensable injury, we further find that the polyneuropathy condition is not compensable. Accordingly, the insurer's "de facto" and written denials shall be reinstated and upheld.

In light of such a finding it follows that there has been no unreasonable resistance to the payment of compensation. Therefore, no attorney fee award under ORS 656.382(1) is warranted. Alternatively, even if we considered the denial to have been premature, no attorney fee award would have been granted. To begin, since claimant acknowledges that she was not seeking compensation, she would not have prevailed against a denial of a claim for compensation. See ORS 656.386(1). Secondly, considering the evolution of Dr. Randall's recommendations and studies, as well as the filing of claimant's hearing request concerning a "de facto" denial, we would not consider the insurer's conduct to have been unreasonable. Therefore, no attorney fee award under ORS 656.382(1) would have been justified.

ORDER

The Referee's order dated December 4, 1991 is reversed. The insurer's denial is reinstated and upheld. The Referee's $2,500 attorney fee award is reversed.

August 20, 1992 Cite as 44 Van Natta 1662 (1992)

In the Matter of the Complying Status of
SUNSET SIDING CONSTRUCTION, INC., Noncomplying Employer
WCB Case No. 91-00509
ORDER DENYING RECONSIDERATION
Christopher Rounds, Attorney
Breathouwer, et al., Attorneys
Saif Legal Department, Attorney
Bottini, et al., Attorneys
Dunn, et al., Attorneys

Sunset Siding Construction has requested reconsideration of our August 6, 1992 Order on Reconsideration. Specifically, Sunset contends that we erred in not granting its motion for an attorney fee award pursuant to ORS 656.740(5).

After reviewing Sunset's motion and memorandum in support, we have nothing further to add to our prior order, but this observation. The appeal referred to in ORS 656.740(5) is to the forum which has jurisdiction over the matter, in this case, the Court of Appeals. Here, we dismissed the request for review for lack of jurisdiction. Under the circumstances, we have no more authority under ORS 656.740(5) to award attorney fees than would a Circuit Court had a party purported to file an "appeal" with that forum.

Consequently, the request for reconsideration is denied. The parties' rights of appeal shall run from the date of our August 6, 1992 Order on Reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES D. TERRY, Claimant
WCB Case No. 90-17722
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Brown's order that declined to award permanent total disability. On review, the issue is permanent total disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and "Ultimate Findings of Fact" with the exception of the second ultimate finding. We add the following supplemental findings.

Between October 3, 1990 and October 24, 1990, Ms. Hagel, a vocational consultant, made 53 job contacts on claimant's behalf in the area of small appliance repair work. (Ex. 165). The results were: 33 employers had no openings, 9 were out of business, 5 jobs were inappropriate due to claimant's limitations, and 6 employers either did not respond to messages left by Ms. Hagel or did not answer their telephone. (Id). Claimant himself made 103 employment contacts between October 3, 1990 and December 19, 1990. (Ex. 166). Nineteen of those contacted were in the area of small appliance repair work. None of the employers contacted had job openings. The 84 other employers contacted represented a variety of potential light duty jobs. Not one of those 84 employers had a job opening for claimant. (Id).

Claimant is unable to sell his services on a regular basis in a competitive labor market.

CONCLUSIONS OF LAW AND OPINION

To prove entitlement to permanent total disability, claimant must establish that he is unable to perform any work at a gainful and suitable occupation. ORS 656.206(1)(a); Wilson v. Weyerhaeuser, 30 Or App 403 (1977). Claimant may prove permanent total disability status by a combination of medical and nonmedical disabilities which effectively foreclose him from gainful employment. Welch v. Bannister Pipeline, 70 Or App 699 (1984). Unless claimant's physical incapacity in conjunction with his nonmedical disabilities renders a work search futile, he must also establish that he has made reasonable efforts to obtain such employment. ORS 656.206(3); SAIF v. School, 92 Or App 594 (1988). Even if a work search would be futile, claimant must nevertheless prove that, but for the compensable injury, he is willing to work. SAIF v. Stephens, 308 Or 41 (1989).

The Referee first concluded that claimant's employment at the time of hearing was "reflective of [claimant's] pluck and the sympathy of the employer" and did not establish that claimant was competitively employable in a theoretically normal labor market. We agree and adopt the Referee's discussion of this issue.

Nevertheless, the Referee concluded that claimant was otherwise regularly employable at suitable employment. Consequently, the Referee found that claimant was not permanently and totally disabled. Specifically, the Referee found that claimant had successfully completed a one-year training program in small appliance repair; that claimant was capable of part-time employment in that field at a probable wage of $5.42 per hour; and that such employment was available in the labor market.

On review, claimant first contends that the parties agreed at hearing that claimant had established a prima facie case of entitlement to permanent total disability and that the issue before the Referee was confined to whether claimant's current employment constituted regular, gainful employment. We agree that claimant's current employment was to be the primary focus of the parties' evidence at hearing. (Tr. 4). However, we do not agree with claimant's suggestion that the Referee improperly addressed claimant's employability more generally.

At hearing, the parties stipulated to certain facts. (Tr. 2). As a policy matter, a referee should accept such factual stipulations unless contradicted by other facts in the record. See Norris and Norris, 302 Or 123, 126 (1986), citing SAIF v. Casteel, 301 Or App 151, 154 (1986). However, the parties did not stipulate that claimant was unemployable but for the possible exception of his current employment. To the contrary, at hearing both claimant and SAIF introduced testimony as to claimant's general employability. (See, e.g., Tr. 30, 36, 48-49). Moreover, SAIF addressed claimant's general employability in its written closing argument without objection from claimant. Under the circumstances, we conclude that it was not improper for the Referee to consider claimant's general employability.

Turning to the merits of this issue, the parties stipulated to the following facts. Claimant is restricted to a wheelchair as the result of the amputation of his right leg above the knee. He has been released to modified light duty work, with significant restrictions. Claimant has a second grade education and is 58 years of age. His arithmetic and reading skills are consistent with that level of education. His vocational history does not qualify him for other than entry-level employment. He has some cognitive deficit and possible brain damage associated with prior employment around fumes. His motivation to return to work is not questioned. He has been entitled to social security disability benefits since October 1987. (Tr. 2).

The record discloses the following additional facts. Claimant's vocational background is that of a trucker and fruit picker. He has discalcula and dyslexia. He underwent training in small appliance repair with Goodwill Industries. In February 1990, due to numerous medically-excused absences, claimant required a two-month extension to finish his training program. In March 1990, Mr. Harrington, his vocational counselor, conducted a general analysis of the vocational goal of small appliance repair. The analysis indicated that such a vocation had: (1) an average wage of $5.42; (2) a projection of 34 openings statewide, and 4 openings in district eight; (3) an unemployed to openings ratio of two-to-one statewide, and one-to-one in district eight; and (4) a turnover that was not indicated as high. Mr. Harrington concluded that reasonable employment opportunities existed in the field of small appliance repair work. (Ex. 149). Claimant completed the training program in April 1990.

We do not find Mr. Harrington's opinion persuasive on the matter of the availability of employment appropriate to claimant. In particular, Mr. Harrington's statement that the labor market numbers indicate reasonable employment opportunities in the field of small appliance repair fails to take into consideration claimant's ability to competitively sell his services in the field considering his capabilities and physical limitations, including the fact that claimant is only able to work on a part-time basis. See Harris v. SAIF, 292 Or 683 (1982); Marjorie I. Janisch, 43 Van Natta 1423, 1424 (1991) (vocational counselor's opinion is not persuasive where he provides no information on the availability of such a job, given claimant's age, physical limitations, and lack of adaptability).

Vocational consultant Jane Hagel testified at hearing that she had identified two seasonal food packaging positions which represented employment opportunities for claimant. (Tr. 48). However, again there is no evidence in the record concerning the availability of any such jobs appropriate to claimant's limitations. See James G. Berry, 43 Van Natta 1354, 1356 (1991). Ms. Hagel also testified that she knew of a particular department store that was trying to develop a program for working with the handicapped. (Tr. 49). However, Ms. Hagel's testimony indicates that this store is merely in the process of developing jobs for handicapped workers; therefore, the availability of any such jobs is speculative and not persuasive. See Gettman v. SAIF, 289 Or 609 (1980). We further note that Ms. Hagel did not offer an opinion regarding the availability of any jobs appropriate to claimant's limitations in the area of small appliance repair work; nor is there any evidence in the record that she conducted a labor market study for such jobs.

Significantly, both claimant and Ms. Hagel made extensive attempts to locate suitable employment for claimant without success until claimant's current employment which, we have concluded, does not establish claimant's employability. Under the circumstances, we find no persuasive evidence regarding the current availability of any jobs appropriate to claimant's limitations. See Thomas F. Scott, 43 Van Natta 1942 (1991) (there is no persuasive evidence regarding the availability of any job appropriate to claimant's limitations and a vocational counselor's opinion that jobs exist is not compelling where claimant demonstrated extensive work search efforts and only obtained work by relentless persistence directed at an employer and then only after the employer became acquainted with him).

As previously noted, the parties stipulated that claimant was motivated to return to work. That stipulation is amply supported by the record. Further, claimant has clearly made reasonable efforts to locate and obtain gainful, suitable employment. Moreover, although claimant is currently employed earning wages, the record persuades us that claimant is not currently able to sell his services on a regular basis in a competitive labor market. See Harris v. SAIF, supra. Accordingly, we conclude that claimant has proven entitlement to permanent total disability compensation.

The effective date of a permanent total disability award is the earliest date when a claimant proves that all elements necessary to his claim existed. Adams v. Edwards Heavy Equipment, Inc., 90 Or App 365 (1988); Arva M. Perkins, 42 Van Natta 2384 (1990). In this case, claimant became medically stationary on May 23, 1990. All vocational and social factors relevant to his permanent and total disability existed at that time. Accordingly, we conclude that the award of compensation for permanent and total disability shall commence as of May 23, 1990. The insurer is authorized to offset any permanent partial disability paid after May 23, 1990 as a prepayment of claimant's permanent total disability compensation. See Pacific Motor Trucking Co. v. Yaeger, 64 Or App 28 (1983).

ORDER

The Referee's order dated February 22, 1991 is reversed. That portion of the Referee's order which declined to find claimant permanently and totally disabled is reversed. In lieu of the Determination Order award of 100 percent (150 degrees) scheduled permanent disability for loss of claimant's right leg, claimant is awarded permanent total disability benefits as of May 23, 1990. The SAIF Corporation is permitted to offset permanent partial disability payments paid subsequent to that date, if any, against claimant's permanent total disability benefits. Claimant's counsel is awarded a fee of 25 percent of the increased compensation created by this order, payable by the insurer, except that total out-of-compensation fees awarded by the Referee and Board shall not exceed $6,000.

August 20, 1992 Cite as 44 Van Natta 1665 (1992)

In the Matter of the Compensation of
KENNETH L. THOMPSON, Claimant
WCB Case No. 91-07007
ORDER ON REVIEW
Black, et al., Claimant Attorneys
David Schieber (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

The SAIF Corporation requests review of Referee Brown's order that: (1) increased claimant's scheduled permanent disability award from 26 percent (12.48 degrees) loss of use or function of the left thumb, as awarded by Notice of Closure, to 23 percent (34.5 degrees) scheduled permanent disability for loss of use or function of his left forearm; and (2) directed SAIF to pay claimant's permanent disability award at the rate of $305 per degree. On review, the issues are extent and rate of scheduled permanent disability. 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

Extent of scheduled disability

The Referee concluded that it could be reasonably inferred that claimant's loss of grip strength was due to nerve damage. Consequently, he awarded claimant a value of 10 percent for his loss of grip strength. On review, SAIF argues that, because claimant has already been compensated for the amputation pursuant to OAR 436-35-110(3)(a), he is not entitled to a separate value for loss of grip strength unless he can prove that the loss is due to nerve damage, rather than the amputation itself.

We are unable to find that the medical evidence in the record specifically establishes that claimant's loss of grip strength is due to nerve damage, atrophy or other anatomical changes, independent of his amputation. Although claimant's treating doctor, Dr. Worland, M.D., checked "Yes" in response to a letter from claimant's counsel that asked whether claimant's left hand grip strength loss was due to his industrial injury, we do not find that Dr. Worland has explained that the loss of grip strength is due to factors other than the amputation. Furthermore, Dr. Worland has not specifically attributed claimant's loss of grip strength either to nerve damage, atrophy or other anatomical changes. See Catherine E. Green, 44 Van Natta 925 (1992).

Under the circumstances, we conclude that claimant has not established that he is entitled to a separate award for loss of grip strength. Accordingly, we reverse the Referee's order and affirm the Notice of Closure award of 26 percent scheduled permanent disability for loss of use and function of the left thumb.

Rate of scheduled disability

The Referee concluded that claimant's award of scheduled permanent disability should be paid at the rate of $305 per degree. He relied on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), in which we held that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. Subsequent to the Referee's order, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992).

In this case, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury. ORS 656.202(2); former ORS 656.214(2).

We, therefore, reverse the Referee on the issue of rate of scheduled permanent disability.

ORDER

The Referee's order dated December 2, 1991 is reversed. That portion of the Referee's order that increased claimant scheduled permanent disability award to 23 percent (34.5 degrees) for loss of use of the let forearm is reversed. The Notice of Closure is reinstated and the award of 26 percent (12.48 degrees) scheduled permanent disability for loss of use or function of the left thumb is affirmed. Those portions of the order that directed the SAIF Corporation to pay claimant's scheduled permanent disability award at the rate of $305 per degree and awarded claimant's attorney an out-of-compensation fee payable from this compensation are reversed.

In the Matter of the Compensation of
RONALD G. CARROLL, Claimant
WCB Case No. 91-04634
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of Referee Schultz's order that: (1) found that claimant's request for hearing was not premature; and (2) set aside its partial denial of claimant's claim for proposed low back surgery. On review, the issues are jurisdiction and medical services. We reverse.

FINDINGS OF FACT

Claimant has an accepted claim for a May 22, 1990 low back strain.

On August 17, 1984, Dr. Kendrick performed a discectomy at L5-S1. Thereafter, claimant did not seek treatment for his low back until the May 22, 1990 lifting incident at work.

A June 14, 1990 MRI revealed degenerative disc disease at L1-2 and L5-S1, mild posterior bulging of the intervertebral disc at L4-5 and L5-S1 and evidence of the prior surgery at L5-S1.

Claimant requested a hearing after the employer notified Dr. Kendrick that it would not approve surgery to correct claimant's destabilization at L5-S1.

The employer requested Director review regarding the proposed surgery. After review, the Director found the proposed surgery to be reasonable and necessary for claimant's condition.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

We adopt the reasoning and conclusion of the Referee on this issue.

Medical Services

The Referee found the surgery proposed by Dr. Kendrick to be compensable as related to claimant's May 1990 low back injury. In reaching this conclusion, the Referee stated that he found the opinions of Drs. Kendrick and Matteri to be more persuasive than those of Drs. Wilson and Rosenbaum. We disagree.

Because claimant has had prior low back problems, prior surgery at L5-S1, and currently has degenerative changes in his low back, there are a number of potential causes for claimant's current need for treatment for his low back problem. Therefore, we find the causation issue to be a complex medical question which must be resolved by expert 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).

Dr. Kendrick, treating physician, acknowledged that claimant's problems at L5-S1 pre-date the 1990 injury. Kendrick performed surgery on that disc in 1984 and currently believes that claimant's chronic back pain is related to the "one abnormal disc" at L5-S1. (Ex. 23-2). Kendrick also described claimant's condition as destabilization "from a disc rupture." (Ex. 22). He stated that the destabilization "was not taken care of by a simple discectomy, nor indeed would one expect it to be. [Claimant] had a decompression with his discectomy, and it took care of his nerve root pain, and in the majority of people there is not enough destabilization from the disc rupture to require a fusion procedure; however, in this man that is not the case." (Id).

Dr. Kendrick does not believe that claimant currently suffers from a ruptured disc. Rather, he associates claimant's need for treatment to "destabilization" which, in turn, he relates to claimant's 1984 condition. Inasmuch as Kendrick believes that claimant's current need for treatment is due to causes

other than the May 1990 compensable injury, his opinion does not support the compensability of the claim. See ORS 656.245.

Although Dr. Matteri apparently found the proposed surgery to be appropriate treatment for claimant's condition, we find no evidence that he expressed an opinion concerning the cause of claimant's need for treatment. (See Ex. 35-2).

Dr. Rosenbaum opined that claimant's imaging studies reveal expected degenerative change at the lumbosacral level consistent with the 1984 surgery. (Ex. 21-3). He noted that claimant's symptoms may be due to degenerative changes, a chronic strain, or degeneration at a different disc space. (Ex. 21-4).

On August 30, 1990, Dr. Wilson opined that claimant's current problems are separate from his previous back injury and that work activities were the major contributing factor to the development of these symptoms. (Ex. 17-1). Wilson's opinion in this regard is based on his finding that nothing else "would better explain" claimant's symptoms. (Id). On March 22, 1991, Wilson opined, "There is no convincing evidence that the patient's pain is not emanating from a low back strain." (Ex. 24-2). Although Wilson also stated that he did not consider claimant's present complaints to be the result of natural progression of a previous injury (Ex. 17), he did not indicate that he was aware of claimant's low back degenerative changes or explain how these changes are or are not related to the 1990 injury. Because Wilson failed to acknowledge undisputed objective findings of degenerative changes, we are not persuaded that his opinion is based on an accurate history. Therefore, we do not rely on his opinion regarding causation. See Somers v. SAIF, 77 Or App 259 (1986).

Based upon careful examination of the record, the three exhibits relied on by claimant (Exs. 20, 22, and 23; all chartnotes and medical reports from Dr. Kendrick) do not, contrary to claimant's contention, causally relate the proposed fusion surgery to claimant's 1990 compensable sprain injury. As previously discussed, Dr. Kendrick instead opines that claimant's chronic pain is directly related to claimant's 1984 problem.

Accordingly, we find no persuasive evidence relating the low back surgery proposed by Dr. Kendrick to claimant's May 22, 1990 work injury. Consequently, claimant has not carried his burden concerning the compensability of his claim. See ORS 656.245.

Finally, because the medical services claim is not compensable, we do not address the employer's request for review of the Director's order which found the proposed surgery reasonable and necessary for claimant's condition.

ORDER

The Referee's order dated October 17, 1991 is reversed. The self-insured employer's denial of claimant's claim for proposed surgery at L5-S1 is reinstated and upheld. The Referee's $1,500 attorney fee award is reversed.

In the Matter of the Compensation of
GUADALUPE M. GONZALES, Claimant
WCB Case Nos. 91-00644 & 91-04090
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Schultz & Taylor, Defense Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Holtan's order which: (1) declined to direct Liberty Northwest Insurance Corporation (on behalf of General Foods Corporation) to pay temporary disability benefits from June 2, 1987 to the present; and (2) declined to assess penalties or

attorney fees for an allegedly unreasonable failure to pay temporary disability benefits pursuant to a March 19, 1991 Order on Review. On review, the issues are temporary disability benefits, penalties and attorney fees.

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

Claimant sustained a low back injury in 1987. Pursuant to a Referee's order, Agripac Inc., also insured by Liberty Northwest Insurance Corporation (Agripac/Liberty), was found to be responsible for a new injury. On review, the Board issued a March 19, 1991 order which found the first employer, General Foods/Liberty, to be responsible for an aggravation claim. Meanwhile, Agripac/Liberty paid temporary disability benefits and processed the claim to closure. An August 10, 1990 Determination Order, which was affirmed October 3, 1990, awarded claimant permanent disability and granted temporary disability benefits from June 2, 1987 through June 29, 1990, the date claimant became medically stationary. The benefits were paid in full by Agripac/Liberty. General Foods/Liberty did not pay any temporary disability benefits.

Claimant contends that General Foods/Liberty should be directed to pay temporary disability benefits from June 2, 1987 until it closes the claim, and any overpayment created by such an order would be subject to offset against future permanent disability awards. The Referee disagreed and declined to direct General Foods/Liberty to pay any additional temporary disability benefits, but instead allowed General Foods/Liberty to "step into the shoes" of Agripac/Liberty with respect to processing the 1987 claim. We agree with the Referee.

Each employer, through its insurer, has a statutory obligation to pay interim compensation if neither has denied the claim. See Petshow v. Ptld. Bottling Co., 62 Or App 614, 618-19 (1983). Here, however, claimant did not contend at hearing that she is entitled to interim compensation payable by General Foods/Liberty. See Opinion and Order at 4. We will not address the issue for the first time on review. See Helen S. Long, 44 Van Natta 119 (1992); Stevenson v. Blue Cross, 108 Or App 247, 252 (1991).

Moreover, even if claimant had established that she is entitled to interim compensation payable by General Foods/Liberty from June 2, 1987 until it denied the claim on December 16, 1987, we would not direct General Foods/Liberty to pay compensation for periods during which claimant has already received compensation from Agripac/Liberty. Ernest J. Meyers, 44 Van Natta 1054, 1055 (1992).

Claimant's substantive entitlement to temporary disability benefits ended on June 29, 1990, the date she became medically stationary. (Exs. 1A, 5A). The Referee found, and claimant does not dispute, that Agripac/Liberty paid all the benefits awarded to claimant, including temporary disability for the period June 2, 1987 through June 29, 1990. Thus, claimant would have us direct General Foods/Liberty to pay temporary disability benefits for the same periods during which claimant has already received all temporary disability benefits from Agripac/Liberty to which she was substantively entitled, thereby creating an overpayment. We decline to authorize such an overpayment. See Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992) (Where claim closure processing delay did not result in overpayment, Board has no authority to impose one). Accordingly, we affirm the Referee's decision and hold that, under these circumstances, claimant is not entitled to additional temporary disability benefits payable by General Foods/Liberty.

Because we have concluded that General Foods/Liberty does not owe any additional temporary disability benefits, it follows that there was no unreasonable delay or refusal to pay compensation, and, therefore, no basis for imposing a penalty.

ORDER

The Referee's order dated October 24, 1991 is affirmed.

In the Matter of the Compensation of
PRESTON E. JONES, Claimant
WCB Case No. 91-07095
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Menashe's order that did not require the SAIF Corporation to pay for two chiropractic treatments per month, when the parties' Stipulated Order provided that SAIF "agrees to pay for palliative chiropractic care of two treatments per month pursuant to OAR 436-10-040(2)(a)." In its brief, SAIF argues that the Referee lacked jurisdiction to address the efficacy of palliative medical services. On review, the issues are jurisdiction and enforcement of a stipulated order. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

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

The Hearings Division generally has jurisdiction over a dispute regarding enforcement of a stipulated agreement. See Howard v. Liberty Northwest Ins. Corp., 94 Or App 283 (1988).

Here, however, claimant's right to palliative treatment under the agreement depends upon application of former OAR 436-10-040(2)(a). See Kevin A. Haines, 43 Van Natta 1041 (1991); compare Louise A. Greiner, 44 Van Natta 527 (1992). By incorporating the rule, the agreement allows SAIF to challenge claimant's continuing palliative chiropractic care on "efficacy" grounds. SAIF did just that. Therefore, we agree with the Referee's conclusion that SAIF's challenge does not violate the terms of the parties' agreement.

Claimant argues that the Director erred in deciding that SAIF successfully challenged the efficacy of the requested treatment and requests that SAIF be directed to pay for two chiropractic treatments per month, despite the Director's order. In effect, claimant asks us to review the Director's order. However, since the Referee's order, we have determined that the Director has exclusive jurisdiction over disputes concerning palliative medical services. Rexi L. Nicholson, 44 Van Natta 1546 (1992).[1] Accordingly, we agree with the Referee's refusal to address claimant's challenge to the Director's order denying authorization for palliative care in this case.

Finally, claimant contends we should not apply the 1990 amendments to Workers' Compensation Law so that SAIF may avoid its contractual obligations under the stipulated agreement. SAIF responds that the new law changes only the forum for litigating a denied request for palliative care, not the contractual obligations.[2] We agree with SAIF.

In reaching this conclusion, we find that the 1990 amendments do not alter the terms of the agreement. The agreement does not establish a forum for resolving disputes arising under it. Moreover, our lack of jurisdiction to review the Director's order denying palliative care is independent of the agreement. Finally, we reiterate that the agreement's incorporation of former OAR 436-10-

[1] Board Member Gunn directs the parties to his dissent in Rexi L. Nicholson, supra, which would have reviewed the Director's order and found it invalid because a panel was not appointed pursuant to ORS 656.327(3).

[2] Board Member Gunn notes if this was simply a dispute over the terms of the stipulation, claimant still would not prevail.

040(2)(a) explicitly allows SAIF to challenge claimant's request for continuing palliative care. For these reasons, we find that application of current law does not permit SAIF to avoid its contractual obligations.

ORDER

The Referee's order dated September 13, 1991 is affirmed.

August 24, 1992 Cite as 44 Van Natta 1671 (1992)

In the Matter of the Compensation of
MINDI M. MILLER, Claimant
WCB Case No. 91-03072
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Schultz & Taylor, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Brittingham's order that declined to assess an attorney fee for allegedly prevailing over the insurer's aggravation denial. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The issues stated at hearing included a request that the Referee: (1) set aside the insurer's aggravation denial; and (2) award an assessed fee to claimant's attorney for prevailing on the aggravation denial issue. The Referee found that the aggravation denial was moot and need not be set aside. He did not address the issue of an assessed fee regarding the aggravation denial. On review, claimant argues that he is entitled to an assessed attorney fee pursuant to ORS 656.386(1) for prevailing on the issue of the aggravation denial.

ORS 656.386(1) provides, in pertinent part, that "[i]n 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." Such a fee is to be paid by the insurer or the self-insured employer.

ORS 656.277(2) provides that a claim that a nondisabling claim has become disabling must be filed as an aggravation pursuant to ORS 656.273, if the claim is made more than a year after the injury. Former OAR 436-30-045(6) provides that "[f]or claims that are reclassified, the aggravation rights begin with the first valid closure pursuant to ORS 656.268." ORS 656.268 deals with disabling claims.

Here, claimant's claim was reclassified as disabling within a year of the date of injury. Prior to this reclassification, the insurer had closed the "nondisabling" claim and denied an "aggravation" claim. We find that the reclassification of the claim as disabling rendered the insurer's prior claim closure and aggravation "denial" ineffective. The reclassification, in effect, declared that the claim remained in open status until it was subsequently closed pursuant to ORS 656.268. An aggravation claim cannot be made until the original claim has been closed and an arrangement for compensation made. ORS 656.273. Therefore, it follows that an aggravation denial made on an open claim has no legal effect.

Claimant does not disagree with the foregoing. Indeed, it was undisputed at hearing and continues to be undisputed on Board review, that the insurer's March 1991 aggravation denial became a nullity, once the insurer reopened and accepted the claim as disabling pursuant to the Determination Order issued on claimant's reclassification request. Nonetheless, claimant argues that by "continuing to support the denial at hearing (i.e., by refusing to withdraw or rescind) claimant must conclude that the

insurer continues to dispute that claimant's condition changed [from nondisabling to disabling] after issuance of the Notice of Closure." (Appellant's brief, p. 3). We disagree.

Even without the Referee's order declaring the denial a nullity, the denial was a nullity by operation of law. Claimant did not require an order setting aside the denial to "set the record straight." We do not find that claimant has "prevailed" over a nullity. Accordingly, claimant is not entitled to an assessed attorney fee under ORS 656.386(1).[1]

ORDER

The Referee's order dated November 29, 1991 is affirmed.

[1] The parties stipulated at hearing that claimant's attorney was instrumental in getting the claim reclassified by the Director. The legislature, however, has not authorized the Board to award attorney fees to a claimant's attorney for such services.

August 25, 1992 Cite as 44 Van Natta 1672 (1992)

In the Matter of the Compensation
STEVE L. BARBER, Claimant
WCB Case No. 91-11066
ORDER ON REVIEW
Karen Werner, Claimant Attorney
David Fowler (Saif), Defense Attorney
Emmons, et al., Claimant Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Nichols' order that upheld the SAIF Corporation's denial of his occupational disease claim for his low back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

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

On review, claimant contends that the Referee mistakenly characterized the claim as one for an occupational disease, rather than an industrial injury. We disagree with claimant.

In opening remarks, claimant's counsel agreed with the Referee that the claim would be based upon claimant's low back condition which was related to work activity and occurred over "a period of about a week." Tr. 1. Moreover, claimant's Form 801 provided claimant's statement that he had been installing deadbolts "all that week." Claimant further reported that by the end of the week his back was very sore, and the next day he went to the hospital. Finally, the medical reports and the record as a whole establish that claimant's low back condition developed gradually and could not be said to be an unanticipated result of claimant's exposure to the work conditions. See James v. SAIF, 290 Or 343 (1981).

Accordingly, we conclude that the Referee properly analyzed claimant's claim as one for an occupational disease, rather than an industrial injury. Valtinson v. SAIF, 56 Or App 184 (1982).

ORDER

The Referee's order dated November 20, 1991 is affirmed.

In the Matter of the Compensation of
RICHARD F. HOWARTH, Claimant
WCB Case No. 91-12789
ORDER ON RECONSIDERATION
Welch, et al., Claimant Attorneys
Katheryn Alvey (Saif), Defense Attorney

Claimant requests reconsideration of our July 28, 1992 Order on Review that reversed the Referee's order that set aside the SAIF Corporation's denial of claimant's occupational disease claim for a disc herniation. Claimant disagrees with our conclusion that the opinion of Dr. Wayson, claimant's treating physician, was neither well-reasoned nor proved to be based on complete information and, therefore, not entitled to greater weight. Claimant argues that we improperly focused only on one sentence in one report, because the "record, as a whole, demonstrates that Dr. Wayson evaluated this case completely." After reviewing claimant's motion and supporting memorandum, we find no reason to reach a different conclusion regarding our evaluation of the medical opinions.

The record in this matter contains five exhibits authored by Dr. Wayson. (Exs. 10A, 11A, 14, 15, 18). Those reports establish that Dr. Wayson first examined claimant approximately five to six weeks after the onset of his symptoms. In addition, the reports show that Dr. Wayson was aware that claimant's employment history was as a construction carpenter and that claimant had a significant degenerative condition at multiple levels of his low back. However, the fact that Dr. Wayson was aware of these underlying facts renders his one sentence statement concerning causation of claimant's herniated disc no less conclusory. Moreover, as we noted in our order, the factor of claimant's preexisting degenerative condition necessitates some explanation for its role in causation of claimant's disc herniation. However, Dr. Wayson does not address that question in his reports.

Consequently, the request for reconsideration is granted and our prior order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our prior order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
HARLEY J. GORDINEER, Claimant
WCB Case No. 90-18726
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of that portion of Referee Emerson's order that awarded claimant temporary total disability benefits from June 28, 1988 through August 31, 1990. Claimant cross-requests review of those portions of the order that: (1) failed to rate the extent of claimant's permanent partial disability; and (2) failed to award penalties for SAIF's allegedly unreasonable failure to pay compensation. On review, the issues are temporary total disability, extent of permanent disability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant is a 57 year old truck driver. In January 1979, he compensably injured his low back when he slipped on ice while wrapping a load of logs for Cigna's insured. Cigna accepted the claim, and claimant ultimately was awarded benefits for 85 percent unscheduled permanent partial disability.

In May 1986, claimant injured his left shoulder and back while working as a truck driver for

SAIF's insured. SAIF accepted the claim, which was closed by an August 21, 1987 Determination Order with an award of only temporary disability benefits.

On June 6, 1988, claimant's condition worsened. He sought treatment from Dr. Meece, a chiropractor, who filed an aggravation claim on claimant's behalf and provided conservative treatment through July 28, 1988. SAIF denied the claim.

Claimant requested a hearing, at which he challenged SAIF's denial and raised, as an alternative issue, the amount of permanent disability benefits awarded by the August 21, 1987 Determination Order. On December 16, 1988, an earlier referee issued an Opinion and Order that found the aggravation claim compensable and set aside SAIF's denial. The referee also found claimant medically stationary as of July 28, 1988 and attempted to close the claim with an award of temporary total disability benefits. She further concluded that claimant's current condition did not warrant an increase in permanent disability and affirmed the August 21, 1987 Determination Order.

SAIF requested review of the referee's order. On July 31, 1990, we issued an Order on Review that affirmed the referee's conclusion that the aggravation claim was compensable. We further held, however, that the referee had improperly attempted to close the claim and we set aside that portion of the order, as well as that portion that affirmed the August 21, 1987 Determination Order. Harley J. Gordineer, 42 Van Natta 1680 (1990).

Upon receipt of our Order on Review, SAIF accepted the claim and, on August 27, 1990, submitted it for closure. The claim was closed by an August 31, 1990 Determination Order, which found claimant medically stationary as of July 28, 1988, and awarded temporary total disability benefits from June 8, 1988 through that medically stationary date.

CONCLUSIONS OF LAW AND OPINION

Temporary Total Disability

The Referee found that claimant was medically stationary on July 28, 1988, and, therefore, concluded that claimant's claim was not prematurely closed. Neither party disputes that holding on review. The Referee, however, further concluded that claimant was procedurally entitled to temporary total disability benefits through August 31, 1990, the date of claim closure. The Referee recognized that there would be an overpayment of amounts actually due and authorized SAIF to offset the overpayment against any future awards of permanent disability benefits.

SAIF contends that claimant was not entitled to the additional benefits because he was released to return to regular work. It relies on a September 29, 1988 letter from Dr. Meece, which indicates that claimant's condition had improved to his pre-aggravation status by July 28, 1988 and that time-loss payments should have ceased at that date. We are uncertain whether that letter constitutes a "written release to return to regular or modified employment," as that phrase is used in ORS 656.268(3)(b). Nonetheless, we conclude that the Referee was without authority to order SAIF to pay temporary disability payments to claimant to which he was not substantively entitled.

As the court noted in Lebanon Plywood v. Seiber, 113 Or App 651 (1992), a worker is substantively entitled to temporary total disability benefits from the onset of disability until the condition becomes medically stationary. The court recognized that, due to delays in claims processing, the actual payment of such benefits often continues until the determination order is issued, thus creating a procedural overpayment. Nonetheless, the court explained that, in such cases, the payment of benefits past the medically stationary date is a consequence of the administrative process of claim closure and not an entitlement. Thus, it concluded that an overpayment cannot be imposed if the processing delay fails to produce one.

In this case, while there is some dispute as to whether claimant was released to return to regular work, it is clear that SAIF did not pay any temporary disability benefits beyond the July 28, 1988 medically stationary date. Accordingly, there was no procedural overpayment of benefits. Because payment of temporary disability benefits beyond that medically stationary date is not an entitlement, the

Referee had no authority to impose an overpayment of benefits past the medically stationary date. Lebanon Plywood v. Seiber, supra.

Permanent Total Disability

In his request for hearing, claimant raised the issue of permanent disability, evidently as an alternative issue if the Referee found that the aggravation claim had not been prematurely closed. The Referee, however, failed to address the issue in his order, and claimant requests that we remand this matter for further proceedings. We find that the issue was properly raised before the Referee. Liberty Northwest Ins. Corp. v. Alonzo, 105 Or App 458 (1991). We conclude, however, that remand is unnecessary, because the record was adequately developed for review. ORS 656.295(5).

Before we rate the extent of claimant's permanent disability, however, we must clarify a procedural matter. In his brief, claimant acknowledges that, although he sustained a compensable aggravation in 1988, the medical evidence fails to establish a permanent worsening of his condition since the August 21, 1987 Determination Order. He argues, however, that he timely requested a hearing on that 1987 Determination Order and has not yet had the opportunity to challenge it. We agree. The record establishes that claimant challenged the Determination Order in the prior hearing in which he also asserted the aggravation claim. (Ex. 26). Although the earlier referee initially affirmed the Determination Order in that proceeding, we set aside that portion of her order on review and effectively deferred claimant's appeal from the 1987 Determination Order to a later date. (Ex. 29-2). Under those circumstances, we conclude that claimant is entitled to a rating of permanent disability as of the time immediately prior to his 1988 aggravation.

In rating the extent of claimant's permanent disability, we consider his permanent impairment attributable to the compensable injury and all of the relevant social and vocational factors set forth in former OAR 436-30-380 et seq. We apply those rules as guidelines, not as restrictive mechanical formulas. Harwell v. Argonaut Insurance Co., 296 Or 505 (1984).

Claimant's condition prior to the 1988 aggravation is well documented in the record. He was examined by the Independent Chiropractic Consultants on April 15, 1987, at which time he reported constant low back pain, stiffness in his neck and back, headaches and cervical discomfort. On examination, he was tender in his left shoulder and his right arm to the wrist. In his low back and down his left leg to his foot he felt stabbing pain, numbness and "pins and needles" sensation. His cervical flexion was 45 degrees and extension 20 degrees. Cervical spine rotation was 55 degrees right and 65 degrees left. Right and left lateral bending was 30 degrees. Lumber forward flexion was 55 to 60 degrees and lumber extension was 15 to 20 degrees. Lateral bending was 20 degrees, and rotation was 20 degrees each way.

Considering claimant's limitations and pain, as well as the relevant social and vocational factors, we find that claimant is substantially disabled. We conclude, however, that it is a disability for which claimant has already been compensated. Pursuant to ORS 656.222, we are obligated to consider any previous awards and payment of permanent disability. Claimant had received an award of 85 percent unscheduled permanent partial disability prior to incurring the 1986 injury which led to the issuance of the August 21, 1987 Determination Order. The medical evidence establishes that claimant's condition following this second injury returned to his pre-1986 injury condition. This fact is further supported by claimant's statement in April 1987 that he felt then about the same as he did prior to the 1986 injury. (Ex. 19-3).

Accordingly, we affirm the August 21, 1987 Determination Order. Moreover, because the claimant's condition did not permanently worsen thereafter, we also affirm the August 31, 1990 Determination Order. Stepp v. SAIF, 304 Or 375 (1987).

Penalties

Claimant contends that SAIF's failure to pay temporary disability benefits was unreasonable and subject to a penalty or attorney fee. We disagree.

ORS 656.262(10) provides, in part:

> "If the insurer of 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."

A penalty may be imposed only if the insurer's conduct in denying compensation was unreasonable. If SAIF had a legitimate doubt as to its liability, its refusal to pay benefits is not unreasonable. International Paper Co. v. Huntley, 106 Or App 107 (1991).

Claimant argues that SAIF acted unreasonably in refusing to pay temporary disability benefits during the appeal of the earlier referee's December 16, 1988 Opinion and Order, which had found the aggravation claim compensable. Claimant overlooks the fact, however, that the appealed order also closed the aggravation claim with an award of temporary total disability benefits through July 28, 1988, the date the referee found claimant medically stationary. Although we later overturned the referee's closure of the claim on review, SAIF was not required to pay additional temporary disability benefits pending our review.

Claimant also contends that SAIF acted unreasonably in refusing to pay benefits after our July 31, 1990 Order on Review, which remanded the claim to SAIF for further processing according to law. At that time, however, some two years had passed since claimant's aggravation claim, and SAIF had evidence indicating that his condition had improved to his pre-aggravation status by July 1988 and that time-loss payments should have ceased at that date. Under those circumstance, we conclude that SAIF had a legitimate doubt as to its liability and did not act unreasonably in failing to commence payment of temporary disability benefits. Accordingly, no penalty is warranted.

ORDER

The Referee's order dated December 30, 1991 is affirmed in part and reversed in part. The Referee's award of temporary total disability from June 28, 1988 through August 31, 1990 is reversed. The August 21, 1987 Determination Order and the August 31, 1990 Determination Orders are affirmed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
KEITH A. GOODRIDGE, Claimant
WCB Case No. 91-06200
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Gail M. Gage (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Hooton.

Claimant requests review of those portions of Referee Garaventa's order that: (1) upheld the SAIF Corporation's denial of claimant's low back injury claim; and (2) declined to assess a penalty for SAIF's allegedly unreasonable denial. On review, the issues are compensability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except that we also find that claimant felt a jarring sensation in his low back on the date of injury.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee first determined that claimant had sustained a compensable middle back injury on February 4, 1991, while working for SAIF's insured. She concluded, however, that claimant's current

low back condition, for which he sought treatment on May 22, 1991, was not compensably related to the on-the-job injury and, therefore, upheld that portion of SAIF's denial. On review, claimant challenges the Referee's latter conclusion, asserting that the medical evidence preponderates in favor of compensability.

In order to establish compensability of his current low back condition, claimant must establish, with medical evidence supported by objective findings, that the February 4, 1991 injury was a material contributing cause of his disability and need for medical treatment. ORS 656.005(7)(a). We find that the causation of claimant's 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. Origer, M.D., who began treating claimant in May 1991, opined that claimant had sustained a lumbar muscle strain related to the February 1991 work injury. Dr. Radecki, M.D., who examined claimant on July 29, 1991, acknowledged that claimant could have strained his back in February 1991, but believed that such a strain would have resolved prior to claimant's seeking treatment in May. Noting that claimant owns a 19-acre parcel of land where he has been setting fence posts, Dr. Radecki suggested that the current low back problems were caused by non-work related activities.

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). In order to make that determination in this case, however, we find it necessary to first determine claimant's credibility, which is an underlying factor for both opinions. If claimant is credible, we must accept the history he has provided and rely on the only opinion in the record that is based on that history.

The Referee did not address claimant's credibility. Nonetheless, we are equally capable of assessing credibility based on an objective evaluation of claimant's testimony. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). Minor discrepancies in testimony are not sufficient to find a claimant not credible. Peterson v. Eugene F. Burrill Lumber, 57 Or App 476, 480 (1982). After our review of the record, we conclude that claimant is credible.

Claimant consistently testified that he reported back pain with hip and leg involvement within a few hours of the injury, both to his employer and to others, including his wife. Although SAIF sought to dispute that testimony, it was never able to establish a convincing contradiction on any material point. It called witnesses, including Marsha Swanson and Robert Elliot Baker, who qualified their testimony on the injury, or claimant's reporting of it, to the point that it is probable that claimant, as well as the employer's witnesses, are telling the truth. Moreover, SAIF did not call its best witness, Shannon Main, who took claimant's statement and transcribed it onto the employer's accident report form and the 801 form. Both those documents support claimant's version that his work-related injury resulted in immediate complaints regarding his low back.

Furthermore, SAIF argued that claimant could not be trusted because he left work as a disgruntled employee. Many employees leave a particular employment under less than desirable circumstances that might produce the desire for revenge. Absent some confirming evidence that this claimant is so motivated, we are unwilling to presume that he is, or that the circumstances of his departure make him, more likely to lie.

Accordingly, we find claimant credible and find Dr. Origer's opinion, which is based on his history, the most persuasive. For similar reasons, we reject the opinion of Dr. Radecki, because it is based on an inappropriate history. Somers v. SAIF, supra. Accordingly, we conclude that claimant has established the compensability of his current low back condition and set aside SAIF's denial in its entirety.

Penalties

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

Attorney Fees

Because claimant has prevailed against a denial of compensation, his 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 $4,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by 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 September 10, 1991 is affirmed in part and reversed in part. That portion of the order that upheld SAIF's denial of claimant's current low back condition is set aside, and the claim is remanded to SAIF for further processing according to law. For services rendered at hearing and on review in overturning that denial, claimant's counsel is awarded an assessed attorney fee of $4,000, to be paid by SAIF. The remainder of the order is affirmed.

August 26, 1992 Cite as 44 Van Natta 1678 (1992)

In the Matter of the Compensation of
GERALD K. HALE, Claimant
WCB Case No. 90-07637
INTERIM ORDER (REMANDING)
Parks & Ratliff, Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Claimant requests review of Referee Fink's order that upheld the SAIF Corporation's denial insofar as it denied claimant's left shoulder injury claim. Following submission of briefs by counsel, claimant, pro se, submitted copies of post-hearing operative reports. On review, the issues are motion to remand and compensability. We grant the motion.

We first note that we have no authority to consider any evidence not already included in the record. Consequently, we view claimant's submission of additional records as a motion for remand. Judy A. Britton, 37 Van Natta 1262 (1985). As neither counsel had an opportunity to review these post-hearing operative reports prior to submitting their Board briefs, copies of these documents were provided to the parties, and a supplemental briefing schedule was implemented. SAIF has now responded, and objects to claimant's remand request.

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, up to the date of hearing, all diagnostic procedures performed on claimant's left shoulder had failed to reveal the cause of his symptoms. Thus, he concluded, claimant had not proven the compensability of his left shoulder condition. By submitting these reports, claimant appears to argue that we should remand to consider evidence demonstrating that his left shoulder symptoms are related to his work activities. Operative reports from claimant's treating orthopedic surgeon and proferred by claimant reveal that, at surgery, claimant was found to have a left shoulder outlet impingement, and a "smashed and torn" biceps tendon, "consistent with an injury as the patient describes."

SAIF opposes the motion to remand, asserting that "the referee's decision in this matter was based to a large degree on claimant's testimony and lack of credibility. Additional medical evidence is not likely to affect this outcome." Further, SAIF argues, "[a]dditional medical evidence would not establish any element that had not already been established."

As to SAIF's first challenge, the Referee recited that claimant had given "2 dates for alleged injury," "about 4 alleged activities or causes of the injury," and several "versions" of the injury. Therefore, the Referee "seriously question[ed claimant's] credibility and conclude[d] he was not a credible witness." Although the Referee indicated that he had reached this conclusion "[a]fter hearing and observing claimant," we find that the Referee's negative credibility finding was based more on perceived inconsistencies in the medical reports and testimony than on 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 credibility finding. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

Our review of the record reveals that in fact claimant did sustain two separate injuries -- on two separate dates and under differing circumstances. The left shoulder injury alone is the subject of this claim; the other injury has been found compensable in another jurisdiction. Considering only those reports in the record that pertain to this claim, we find claimant's reporting of his injury and symptoms to be consistent and conclude that he is credible. Moreover, we note that whether claimant correctly or incorrectly perceived that he had "torn" something in his left shoulder has no bearing on his credibility. Claimant's opinion as to the nature of his injury is reasonable, because he is not a medical expert. See Wendy K. Sprinkle, 44 Van Natta 814 (1992). Therefore, after considering the record as a whole, we find claimant's reporting and testimony to be consistent and conclude that he is credible.

SAIF also opposes remand because additional medical evidence would not establish any element that has not already been established. Yet, up to now, the gist of SAIF's argument has been that because the "medical evidence is less than clear. . . the denial should be upheld." (Tr. 7). Claimant is now offering to provide surgical reports that could confirm the compensable causation of his left shoulder symptoms. Under these circumstances, 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 question of whether claimant has a compensable left shoulder condition, 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 Presiding Referee to appoint a referee to reopen the record for the admission of additional evidence regarding claimant's post-hearing surgeries. In addition, the appointed referee shall allow SAIF an opportunity to cross-examine or rebut this late-produced evidence. See Wendy K. Sprinkle, supra.

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, the appointed referee shall provide an interim order on remand explaining the effect, if any, the admission of any additional evidence has upon the 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
ROBERT L. HALE, Claimant
WCB Case No. 91-01330
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Kinsley, Brazeau, and Hooton.

Claimant requests review of that portion of Referee Garaventa's order that declined to assess a penalty and related attorney fee for the insurer's miscalculation of his temporary total disability rate. On review, the issue is penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following additional finding:

The insurer had a legitimate doubt of its liability for a higher temporary total disability rate until claimant supplied additional wage information on the day before the hearing.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's conclusions and opinion, with the following supplementation:

As noted by the Referee, once the insurer became aware that it had initially miscalculated claimant's temporary disability rate based on incorrect information provided by its insured, it made repeated attempts to gain accurate information by contacting claimant's attorney. The requested information was not provided, however, until one day before the hearing. Once the requested information was received, the insurer immediately corrected its previous error.

Under the aforementioned circumstances, we do not find the insurer's delay in the payment of compensation to have been unreasonable. We note that an insurer does have the duty to process claims and pay compensation in accordance with applicable law. We conclude, however, that where a worker purposely refuses to provide the information needed to make that processing possible, an insurer's failure to process in a timely manner is not unreasonable. Compare Michael L. Whitney, 37 Van Natta 688 (1985).

ORDER

The Referee's order dated May 28, 1991, as reconsidered on June 25, 1991, is affirmed.

Board Member Hooton, dissenting.

The majority finds that both the employer and the insurer are excused for failing to pay claimant's temporary total disability at the correct rate because "[t]he insurer had a legitimate doubt of its liability." On the present record, that finding is neither sufficient nor appropriate.

ORS 656.266 places the burden of proving the compensability of an injury or occupational disease, and the nature and extent of any disability, on the claimant. This provision, however, has never been read so far as to excuse the obligation of an insurer to investigate and process the claim, or to pay claimant benefits to which he is entitled. ORS 656.262(1) places the burden of processing squarely on the shoulders of the insurer and requires the employer to render whatever assistance the insurer may require. ORS 656.262(3) provides a mechanism by which the insurer may charge off any penalty due claimant for conduct of the employer directly to the employer. This provision is rendered meaningless if conduct by the employer can be utilized as a defense to a penalty otherwise due. In the present claim, this means that it is not sufficient to determine whether the insurer had a legitimate doubt as to its liability, one must also determine whether the employer properly provided information requested by the insurer, and whether the insurer's reliance on that information was reasonable. Based upon the present record, no reasonable trier of fact could determine that the employer provided the

necessary information when it was requested by the insurer. Neither could a reasonable trier of fact determine that the insurer had done all that it was required to do in processing the claim.

On July 9, 1990, claimant provided to his employer a Form 801 reporting an injury to his right wrist occurring on July 6, 1990. The employer apparently completed its portion of the Form 801 also on July 9, 1990, indicating that claimant left work at eight o'clock in the morning on July 9, 1990, and reporting that the injury happened as described by claimant and in the course and scope of his employment. The employer further reported that claimant worked a variable schedule and that his wage also varied. (Ex. 1). The Form 801 specifically directs the employer to specify on the form the total weekly wage, and to attach claimant's payroll record, if wages vary. The employer did not provide claimant's weekly wage, and the form does not indicate whether the payroll records were attached. The form was received by the insurer on July 13, 1990 and the claim accepted on July 24, 1990. Notice of the acceptance, however, was not provided to the claimant until July 31, 1990. (Ex. 2).

It appears that sometime thereafter the insurer received, with or without supplemental request, a computer-generated report from the employer indicating that claimant's total wages for the period from April 12, 1990 to July 5, 1990 were $2,522.56. (Ex. 6). (The document is stamped with a receipt date by the insurer, but the date is illegible.) Pay stubs submitted by the claimant, however, indicate that claimant's total wage on July 1, 1990 was $2,522.56, and that claimant had earnings thereafter, but prior to the date of injury. (Ex. A). Claimant left work on July 9, 1990, (Ex. 1), and was not thereafter released to return to work until September 17, 1990. (Ex. 7).

On January 31, 1991 claimant requested a hearing, citing as issues improper TTD rate and penalties and fees. By stipulation at the hearing, the insurer and claimant's attorney's office were in telephone contact from January through March 1991 regarding the time loss rate, and the insurer, during those conversations, requested that claimant provide documentation of his wages. (Tr. 7). There is no evidence that the insurer took any other action upon learning that claimant disputed the time loss rate.

Based upon this evidence it is clear that the employer maintained, as a part of its regular business records, claimant's total accrued annual wages and all regular deductions therefrom. It is also clear that as of July 15, 1990, the date of its last regular paycheck to the claimant, the employer knew that his total accrued wages exceeded $2,522.56, the amount reported to the insurer. If the employer provided the computer-generated wage information to the insurer after July 15, 1990 it knew that information to be incorrect at the time it was provided. In addition it seems appropriate to charge an employer with knowledge of the record-keeping systems it employs, and therefore, knowledge that claimant's additional earnings after July 1, 1990 would not appear on the computer-generated accrued calculations until the end of the appropriate pay period. Consequently, even if the employer provided the computer-generated summary before July 15, 1990, it knew, or should have known, that the information was not accurate. Finally, the employer took no steps to correct the information provided to the insurer after July 15, 1990, when it had certain knowledge of the erroneous reporting of wages.

The employer need not understand the workings of the compensation system to respond to the insurer's request. It did not need to know the uses to which the information provided would be put in order to fulfill its statutory obligation to provide the insurer with any information the insurer requested. All it had to do was provide the insurer with accurate information when requested to do so. It did not. Furthermore, the employer offered no explanation for its failure to do as the statute requires.

To establish his entitlement to a penalty the claimant need only demonstrate that the insurer or the employer failed to conform to the requirements of the Workers' Compensation Law. If he does so, he has established a prima facie case for a penalty award. If there is an explanation for the failure that would absolve the employer and the insurer from liability, the claimant could not know it and need not search for it. The interest of the insurer and the employer to avoid such a penalty is sufficient to cause it to produce any exculpatory evidence within its control. The Board has long recognized and applied this principle, relying upon the insurer's or employer's failure to provide an explanation as an adequate basis for a finding that a delay or refusal is unreasonable. See Helen M. Chase, 42 Van Natta 1850, 1853 (1990); Ronald L. Matthews, 41 Van Natta 1062 (1989). Neither the Referee nor this Board should indulge in speculation regarding possible explanations for the insurer's or the employer's failure to meet the requirements of the statute. If there is an explanation, the insurer or the employer know what it is and should provide it.

While the evidence of the employer's failure to provide accurate information to the insurer as required by ORS 656.262(3) is sufficient to support a penalty award in and of itself, the insurer does not escape culpability in this instance. Its reliance upon the information provided by the employer without additional investigation was improper. ORS 656.262(1) places the burden of investigation and processing on the insurer. This insurer relied upon wage information provided by the employer in making time loss payments. The information provided by the employer indicates that claimant was terminated on July 5, 1990, despite the fact that claimant was acknowledged to have been injured in the course of his employment on July 6, 1990 and to have left work on July 9, 1990. The evidence provided necessarily excludes potential earnings on the date of injury, even if the insurer deemed, for whatever reason, that it was otherwise reliable. The insurer's failure to seek complete wage information thereafter is not excusable without explanation.

In addition, in January of 1991, when the insurer first learned that claimant disagreed with the determination of average weekly wage it apparently took no steps to verify with the employer the wage information previously provided. Instead, in violation of ORS 656.262(1), it required the claimant to come forward with wage information and act as claims processor on his own behalf.[1]

The evidence in the present record amply demonstrates that the conduct of the employer, the insurer, or both failed to conform to the requirements of ORS 656.262. Neither the employer nor the insurer offered an explanation for that failure. Under these circumstances claimant is entitled to a 25 percent penalty on all time loss due as a consequence of the adjustment of his average weekly wage. Because the Referee and the majority ignore the obligations of the employer and the insurer under ORS 656.262, I dissent.

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[1] While the insurer's Respondent's Brief indicates that it requested new information from the employer and the employer provided the same information it had original forwarded, there is no evidence in the record to support that allegation. The insurer's allegation could be accepted as a concession that the employer had failed to meet the requirements of ORS 656.262(3), as outlined above. However, because that concession does not come from the employer, it would not control any dispute between the employer and the insurer regarding the employer's obligation to reimburse the insurer for the amount of any penalty imposed.

In the Matter of the Compensation of
CHERIE F. SMITHERS, Claimant
WCB Case No. 91-01686
ORDER ON REVIEW (REMANDING)
Ainsworth, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Mongrain's order which dismissed her request for hearing on the ground that she failed to appear at hearing. On review, the issue is whether claimant's request for hearing should have been dismissed. We vacate the Referee's order, reinstate claimant's hearing request, and remand.

FINDINGS OF FACT

Claimant lives in California. Her aggravation claim was denied on February 5, 1991. Claimant, pro se, requested a hearing on the denial and a hearing was scheduled for May 3, 1991 in Medford, Oregon.

Subsequent to her request for hearing, claimant contacted a Eugene, Oregon attorney for purposes of representation on her denied claim. She was thereafter referred to Michael Balocca, a Medford, Oregon attorney. Claimant contacted Balocca, who requested a copy of claimant's file from the Eugene attorney.

On April 16, 1991, claimant, pro se, requested a postponement of the scheduled May 3, 1991 hearing, explaining that she needed additional time to obtain the services of counsel. The Referee granted claimant's motion for postponement.

After reviewing her file, Balocca advised claimant that she did not need an attorney because the employer's denial was one involving palliative medical care. Balocca advised claimant that her physician was required to file certain forms in order to appeal the employer's denial.

Thereafter, claimant contacted the Department and was advised to proceed with her original plan to have a hearing. Claimant's hearing was rescheduled for August 22, 1991 in Medford, Oregon.

Claimant thereafter contacted Mr. Balocca about the rescheduled August 22, 1991 hearing. Balocca advised that he had previously scheduled a vacation that would conflict with the hearing.

In an August 13, 1991 letter to the Referee, Balocca indicated his desire to represent claimant and requested postponement of claimant's August 22, 1991 hearing due to his previously scheduled vacation. Soon thereafter, claimant also contacted the Referee by telephone requesting a postponement. The Referee deferred ruling on claimant's request and instructed her to contact him by telephone on the date of the hearing. Claimant did as requested by the Referee. Mr. Balocca did not appear at the hearing.

The Referee convened the hearing as scheduled on August 22, 1991. The employer objected to claimant's request for a postponement and moved for dismissal on the ground that neither she nor her attorney appeared at the hearing. The Referee denied claimant's request for postponement and dismissed her request for hearing, concluding that the failure of claimant and her attorney to appear was unjustified.

CONCLUSIONS OF LAW AND OPINION

On review, claimant contends that the Referee abused his discretion in denying her motion for postponement and in dismissing her hearing request for failing to appear pursuant to OAR 438-06-071.

OAR 438-06-071(2) provides that a referee may dismiss a request for hearing if claimant and her attorney fail to attend a scheduled hearing, unless extraordinary circumstances justify postponement or continuance of the hearing. A postponement requires "a finding of extraordinary circumstances beyond the control of the party or parties requesting postponement." OAR 438-06-081.

The Referee denied claimant's request for postponement on the ground that she had been given a prior postponement to allow her to obtain counsel, but that she had failed to do so by the time of the rescheduled hearing. We conclude, however, that claimant did essentially everything she could to obtain counsel, but that circumstances beyond her control prevented her from completing her task.

As previously noted, claimant first sought counsel from an attorney in Eugene. Upon referral to a Medford attorney, claimant immediately made contact and followed counsel's instructions regarding her claim. While counsel considered whether to represent her, claimant made the appropriate requests for postponement. She also ultimately followed the Referee's specific instructions that she make telephone contact on the day of the hearing.

We note that the Referee did not rule on claimant's request for postponement until the hearing had been convened. He had also instructed claimant to effectively "appear" by way of telephone on the hearing date. It is unknown whether claimant would have personally appeared at the hearing site if her postponement request had been denied prior to the hearing. In any event, we conclude that claimant made at least reasonable efforts to prosecute her claim, but that surrounding circumstances frustrated those efforts. Under these circumstances, we conclude that the Referee abused his discretion in denying claimant's postponement request. We also conclude that substantial justice will be done by allowing claimant the hearing she seeks. Accordingly, we vacate the Referee's order and reinstate claimant's request for hearing.

ORDER

The Referee's order dated October 1, 1991 is vacated. Claimant's request for hearing is reinstated and this matter is remanded to the Hearings Division with instructions to schedule a hearing in the normal course.

August 26, 1992 Cite as 44 Van Natta 1684 (1992)

In the Matter of the Compensation of
CHARLES W. TEDROW, Claimant
WCB Case No. 91-09918
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Bailey & Associates, Defense Attorneys

Reviewed by Board Members Hooton and Kinsley.

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

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's current request for medical services is sufficiently related to his compensable injury. The employer does not dispute that finding. Rather, it argues that the Referee erred in failing to bar claimant's current claim for medical services on principles of res judicata.[1]

"Preclusion by former adjudication," generally referred to as res judicata, is a "doctrine of rules and principles governing the binding effect on a subsequent proceeding of a final judgment previously entered in a claim." Drews v. EBI Companies, 310 Or 134 (1990). The term comprises two doctrines, claim preclusion and issue preclusion. Issue preclusion bars future litigation of a subject issue only if that issue was actually litigated and determined in a setting where the determination of that issue was essential to the final decision reached. North Clackamas School Dist. v. White, 305 Or 48 (1988). In comparison, claim preclusion bars future litigation not only on every claim included in the pleadings, but also every claim that could have been alleged under the same aggregate of operative facts. Million v. SAIF, 45 Or App 1097, rev den 289 Or 337 (1980). Claim preclusion does not require actual litigation of an issue; however, it does require the opportunity to litigate, whether or not used. Drews, supra.

In this case, claimant filed a claim for a low back injury, which the insurer accepted and processed to closure in 1982. In December 1989, claimant experienced increased low back pain and sought additional treatment. Dr. Newby, a neurologist, diagnosed a recurrent disc herniation and requested authorization for surgery. In March 1990, the insurer denied the request, as well as an aggravation, stating that the need for surgery arose from noncompensable activities. Although claimant initially requested a hearing, that request was withdrawn after a February 1990 MRI scan showed no disc herniation and Newby rescinded his recommendation for surgery.

Later, in January 1991, claimant returned to Newby with complaints of increased back pain. This time an MRI scan showed that claimant had a herniated disc. After conservative treatment failed to provided relief, Newby again requested authorization for surgery.

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[1] We note this dispute concerns the question whether claimant is entitled to file a claim for medical services as a matter of law. Accordingly, it is a "matter concerning a claim" subject to the initial jurisdiction of our Hearings Division. ORS 656.704(3); Kenneth W. McDonald, 44 Van Natta 692 (1992).

The insurer argues that the new request for surgery is barred by virtue of the fact that it arises from the same set of operative facts that was deemed unrelated to the compensable injury when claimant withdrew his prior request for hearing. It essentially contends that, because its March 1990 denial of a causal relationship between the compensable injury and the need for treatment was allowed to become final, everything that follows is, consequently, not compensable. We disagree.

In this proceeding, claimant is not reasserting the prior medical services and aggravation claims. Rather, he is asserting a new medical services claim. When a claimant reasserts a claim for medical services after being previously denied, the question is whether his condition has changed so as to have created a new set of operative facts that previously could not have been litigated. Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560 (1989); Argonaut Ins. Co. v. Rush, 98 Or App 730 (1989). Because a January 1991 MRI scan reveals that claimant now has a herniated disc, whereas a February 1990 MRI scan revealed no disc herniation, claimant's condition has changed and, consequently, his claim for treatment is not barred by res judicata.

The employer also contends that the Referee erred in ordering it to pay for all medical services to diagnose or treat claimant's low back condition from the date of its earlier denial through the date of hearing. It argues that its prior denial was effective not only for claimed treatment prior to its effective date, but also for all subsequent requests for medical services arising from the same off-the-job incident identified in that denial.

We acknowledge that an employer may deny a current claimed need for medical services, or specific claims for a particular treatment, provided that the medical services are not compensably related to the industrial injury. Green Thumb, Inc. v. Basl, 106 Or App 98 (1991). However, an employer may not deny its future responsibility for payment of benefits relating to a previously accepted claim. Boise Cascade Corp. v. Hasslen, 108 Or App 605 (1991). Thus, contrary to the employer's assertion, its prior denial of a then-current claimed need for treatment cannot, as a matter of law, act as a denial of additional medical treatment for a changed condition requested at a later date.

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 medical services 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), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated October 28, 1992 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
BYRON E. BAYER, Claimant
WCB Case No. 91-07156
ORDER ON REVIEW
Black, et al., Claimant Attorneys
David Lillig (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Brown's order that upheld the SAIF Corportion's denial of his aggravation claim for his low back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

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

In 1971, claimant injured his low back while working in a lubrication bay in a gas station. SAIF accepted the claim and in 1972, as a result of the compensable injury, claimant had a fusion from L4 to the sacrum level.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that, because claimant's 1972 lumbar fusion was the major cause of his current condition, claimant had failed to establish compensability of his aggravation claim for a worsened condition resulting from the 1985 industrial injury. We disagree.

On review, claimant contends that, because SAIF failed to follow the notification process prescribed by ORS 656.308(2), it may not argue that responsibility for claimant's low back claim lies with another employer or insurer. ORS 656.308(2) provides, in part:

> "Any employer or insurer which intends to disclaim responsibility for a given injury or disease claim on the basis of an injury or exposure with another employer or insurer shall mail a written notice to the worker as to this position within 30 days of actual knowledge of being named or joined in the claim. The notice shall specify which employer or insurer the disclaiming party believes is responsible for the injury or disease. The worker shall have 60 days from the date of the mailing of the notice to file a claim with such other employer or insurer. Any employer or insurer against whom a claim is filed may assert, as a defense, that the actual responsibility lies with another employer or insurer, regardless of whether or not the worker has filed a claim against that other employer or insurer, if that notice was given as provided in this subsection." (emphasis supplied).

In the present case, SAIF denied claimant's aggravation claim on the ground that the major cause of his current condition and need for treatment "is preexistent to your April 30, 1985 work injury." However, in opening remarks at hearing, counsel for SAIF contended that claimant's "current problem is a result of the spinal fusion in 1972." (Tr. 3). Counsel for SAIF also stated that "the application should have been made through own motion status in the 1972 claim." (Tr. 3).

Here, medical evidence indicates that, at the time it denied his claim, SAIF was aware that claimant's current problems were possibly related to this earlier compensable injury and fusion surgery. (Ex. 39-13). Under the circumstances, we find that SAIF's denial was based upon an assertion that the prior employer (also insured by SAIF) was responsible for claimant's low back condition. Moreover, we agree with claimant's argument that there is no evidence that SAIF notified claimant of its intent to disclaim responsibility for his low back condition on the ground that his current condition was attributable to his prior injury or surgery. For that reason, claimant was left without an opportunity to file a claim against the prior employer.

Therefore, as a result of SAIF's failure to follow the notification process required by ORS 656.308(2), SAIF may not now argue that the prior employer is responsible for claimant's claim.

Accordingly, we consider the merits of claimant's aggravation claim while disregarding SAIF'S contention that the prior employer is responsible.

An aggravation has two components: causation and worsening. Both must be established, unless one is conceded. In the present case, we first conclude that claimant has established that his 1985 injury is a material contributing cause of his worsened condition. Claimant's treating doctor, Dr. Dunn, M.D., reported on February 14, 1991 that claimant's claim should be "reopened for aggravation resulting from his injury and subsequent surgery and resultant stenosis." On June 27, 1991, Dr. Dunn reported that claimant had "progressive deterioration associated with and initiated by his lumbar strain of 1985." Dr. Dunn also dismissed contributions to claimant's conditions by subsequent work exposure and he did not find any "natural degenerative" or new injury. Finally, Dr. Dunn stated that, although claimant's 1971 injury may have contributed to claimant's deterioration in 1985, it was not the major contributing cause. Rather, Dr. Dunn opined that the "major contributing cause" of claimant's condition was the 1985 injury.

We conclude that, as claimant's treating physician and the physician who operated upon claimant following the 1985 injury, Dr. Dunn is in the best position to offer an opinion on causation of claimant's condition. We find his opinion persuasive as it considers other possible contributions to claimant's condition, including the prior injury, degeneration, and subsequent work exposure. Under the circumstances, we find that claimant has established that the 1985 injury is a material contributing cause of his worsened condition.

Next, claimant must show increased symptoms or a worsened underlying condition and a resultant diminishment of earning capacity since the last award or arrangement of compensation. See Leroy Frank, 43 Van Natta 1950 (1991). The worsening must be more than a waxing and waning of symptoms contemplated by the previous award of permanent disability. ORS 656.273(8). In addition, the worsening must be established by medical evidence supported by objective findings. ORS 656.273(1).

Both Dr. Dunn and his partner, Dr. Ewald, who also treated claimant, have opined that his condition has worsened from the last award of compensation. Prior to the last award of compensation, claimant was not experiencing pain during physical therapy unless he pushed himself with additional weights. At that time, claimant's range of motion findings included forward bending to 75 degrees; right side bending to 20 degrees; left side bending to 30 degrees; and straight leg raising to 70 degrees.

However, on February 14, 1991, Dr. Dunn reported that claimant's forward bending was restricted with severe spasm. He also found diminished sensation in the L5 and S1 root distribution, in addition to weakness of the quadriceps. Dr. Dunn concluded that claimant's stenosis had progressed with obvious objective signs of deterioration.

In addition, Dr. Ewald reported that when he evaluated claimant in July 1991, claimant had range of motion limitations of 45 degrees forward flexion; 5 degrees lateral flexion bilaterally; and positive straight leg raising response at 45 degrees. Dr. Ewald concluded claimant's reduced range of motion findings were objective evidence of a worsening from the prior closure.

Accordingly, we find that claimant has established a worsened condition since the August 1990 stipulation, which was the last award of compensation. We also find that the reports of Drs. Dunn and Ewald constitute medical evidence supported by objective findings.

Furthermore, claimant has established that his worsened condition has resulted in a diminishment of earning capacity since the August 1990 stipulation. At the time of the stipulation, claimant was working seven days per week and up to 13 hours per day. However, on November 29, 1990, Dr. Dunn reported that claimant was "digressing (sic) to the point of not being able to have gainful employment except on a part-time basis." Additionally, Dr. Ewald reported on September 24, 1991 that claimant's worsened condition had resulted in a reduced ability to work. Accordingly, we find that claimant has established a diminished earning capacity since the last award of compensation.

Finally, the August 1990 stipulation provided that the parties agreed that the award was made in contemplation of future waxing and waning of claimant's symptoms. Therefore, we consider whether

claimant's worsened condition was more than a waxing and waning contemplated by the Stipulated Order.

Prior to the stipulation, claimant had completed physical therapy and had not been experiencing pain during the therapy, unless he pushed himself. Claimant's range of motion findings had improved in several respects from his initial evaluation and he was managing his pain through his exercises and one to two Indocin tablets per day. However, subsequent to his worsening, claimant underwent a series of injections in an attempt to relieve his low back pain. Additionally, he had increased numbness with loss of sensation, increasing "give-outs" of the left leg and restriction of motion. Dr. Dunn also found that claimant also had increasing immobility of the lumbar spine and severe spasms and restriction of motion.

Based upon the medical evidence as a whole, we conclude that claimant has established that his worsened condition was more than a waxing and waning of symptoms contemplated by the prior award.

We conclude that claimant has established both the causation and worsening components of his aggravation claim for his low back condition. Accordingly, we reverse the Referee on the issue of aggravation.

Claimant is entitled to an assessed attorney fee for prevailing on the aggravation issue. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review concerning the aggravation issue is $3,000, 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 complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated October 31, 1991 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for acceptance and processing according to law. For services at hearing and on review concerning the issue of aggravation, claimant's counsel is awarded an assessed attorney fee of $3,000, to be paid by SAIF.

August 27, 1992 Cite as 44 Van Natta 1688 (1992)

In the Matter of the Compensation of
DONALD J. BIDNEY, Claimant
WCB Case No. 91-13048
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of Referee Menashe's order that: (1) found that the Director did not have jurisdiction over this medical services dispute; and (2) vacated a Director's Proposed and Final Order. Claimant cross-requests review of that portion of the Referee's order which declined to assess a penalty or related attorney fee. Should we decide the Director has jurisdiction over this matter, claimant moves the Board to remand this matter for admission of a November 12, 1991 report by Dr. Nash. The issues are remand, medical services, jurisdiction, penalties and attorney fees. We conclude that the Director had jurisdiction over this matter, deny the motion for remand, and, reviewing for substantial evidence, we affirm the Director's order.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant contends that the Referee erred in declining to admit an August 12, 1991 report from his attending physician, Dr. Nash. Claimant asks us to remand this matter to the Referee or to the Director for admission of the medical report.

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).

The evidence which claimant now offers is an August 12, 1991 report by claimant's attending physician, Dr. Nash, which addresses the reasonableness and necessity of claimant's proposed surgery. This report is dated more than two months after the Director closed the record on May 30, 1991. (Ex. 30). While we agree that this report was not available to be submitted before the Director, we find that the record is not insufficiently developed without it.

Here, claimant wishes Dr. Nash's report considered because of his opinion regarding the reasonableness and necessity of the proposed cervical surgery. However, the record already contains reports from Dr. Nash which address the reasonableness and necessity of claimant's proposed cervical surgery. Thus, we find that the medical report is cumulative evidence. Accordingly, we deny the motion to remand.

Jurisdiction

SAIF sought Director review of this dispute in April 1991. On August 28, 1991, the Director issued a Proposed and Final Order concluding that claimant's proposed medical treatment was not appropriate. The Referee concluded that since medical services claim had been "de facto" denied and the hearing process had already been invoked before SAIF filed its request for Director review, jurisdiction over this matter was with the Hearings Division and not the Director. The Referee also held 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 with both bases for the Referee's conclusion that the Director did not have jurisdiction.

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."

We have held 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, subsequent to the Referee's order 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).

However, notwithstanding the fact that the Director had original jurisdiction over this dispute and had authority to issue his order, the Referee did have jurisdiction in this case to review the Director's order for substantial evidence. ORS 656.327(2); Al S. Davis, 44 Van Natta 931 (1992).

In his August 28, 1991 order, the Director concluded that the proposed surgery was not appropriate medical treatment. 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, 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).

On June 29, 1989, Dr. Nash, a neurosurgeon, recommended cervical surgery at the C5-6 level. On December 14, 1990, Dr. Nash noted that claimant had an established diagnosis of cervical neuroradiculopathy, C6, due to cervical spondylosis and bilateral foraminal stenosis at C5-6. Nash also noted that there was significant cord compromise, of a rotary type, with narrowing of the sagittal diameter of the canal at the C5-6 level. He opined that claimant was in need of surgical decompressive surgery for both release of the cervical canal stenosis and the entrapped nerve, bilaterally, at C5-6. In April 1991, Dr. Nash agreed with a statement that the proposed cervical surgery was a reasonable and necessary treatment and that there was both objective and subjective medical evidence of the condition requiring cervical surgery.

Claimant was examined by Dr. Neufeld, an orthopedic surgeon, Dr. Wilson, a neurologist, and Dr. Glass, a psychiatrist, of the Medical Consultants Northwest. They felt that surgery was contraindicated because of significant psychological factors affecting claimant's physical condition.

Dr. Berkeley, neurosurgeon, performed a neurosurgical consultation on August 4, 1989. As a result of the consultation Berkeley recommended an anterior cervical discectomy and interbody fusion at C5-6 and C6-7. On January 24, 1991 Berkeley opined that the recommended anterior cervical discectomy and interbody fusion at C5-6 and C6-7 was necessary treatment for claimant's cervical spondylosis. Dr. Berkeley's chart notes of August 15, 1990 and October 24, 1990 also indicate that Dr. Berkeley recommended the cervical surgery for claimant's condition.

Dr. Silver, neurosurgeon, served as medical reviewer for the Director. Silver diagnosed cervical spondylosis. He opined that the degree of cervical spondylosis present would not produce the restriction of neck motion that claimant showed. He felt that this restriction was a voluntary phenomenon without a physical basis. Silver felt that the proposed surgery was inappropriate for the diagnosed condition and he could not confirm Dr. Berkeley's findings that indicated cord or root compression. He felt the muscle weakness was of giveaway-type because there was no atrophy and claimant could make a full effort for a few seconds. Dr. Silver felt this confirmed the functional aspect of the weakness. Silver stated that reflexes were symmetric and normal. He felt that they would be expected to be decreased in radiculopathy or increased in myelopathy and they were not. There were no Babinski or Hoffman signs and the sensory examination was non-anotomic. Finally Dr. Silver opined that the only benefit of proposed surgery would be its placebo effect. Dr. Silver felt the risk of surgery would exceed the physical benefit of the proposed surgery.

We conclude that the record, viewed as a whole, would permit a reasonable person to rely on Dr. Silver's opinion, which is supported by that of Drs. Neufeld and Wilson. Moreover, such a finding is reasonable in light of the countervailing, as well as supporting evidence. Based on this record, we must conclude that substantial evidence supports the Director's findings and his conclusion that the proposed surgery is not appropriate. Accordingly, the Director's order is affirmed. ORS 656.327(2).

Penalties and Attorney Fees

Claimant argues that SAIF's failure to refer this claim to the Director within 90 days constitutes an unreasonable resistance to the payment of compensation entitling claimant to penalties. However, because we have affirmed the Director's order finding that the proposed surgery is inappropriate treatment, 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); Dianna L. Dowell, 44 Van Natta 1213 (1992).

ORDER

The Referee's order dated November 26, 1991, as reconsidered January 27, 1992 is reversed. The Director's order dated August 28, 1991 is affirmed.

In the Matter of the Compensation of
WILLIAM J. BOS, Claimant
WCB Case No. 91-08867
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Spangler's order that: (1) admitted evidence of a prior workers' compensation proceeding; and (2) upheld the insurer's denial of claimant's left inguinal hernia injury claim. On review, the issues are evidence and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

At hearing, the Referee admitted five documents pertaining to a claim filed by claimant in 1988 for a right inguinal injury that claimant alleged had been sustained at work while lifting steel shelves. The Referee in that proceeding found that claimant failed to prove compensability on the basis that claimant and his witnesses provided inconsistent testimony and, therefore, were not credible in comparison to the testimony by defense witnesses. (Ex. 5).

Claimant asserts that the contested evidence constituted inadmissible evidence of "other crimes, wrongs or acts" under OEC Rule 404(3). Furthermore, claimant contends that the evidence was not relevant, see OEC Rule 401, and that any probative value was outweighed by the danger of unfair prejudice, see OEC Rule 403.

ORS 656.283(7) provides that "the referee is not bound by common law or statutory rules of evidence * * * and may conduct the hearing in any manner that will achieve substantial justice." This statute is interpreted as giving broad discretion to the Referee in regards to the admissibility of evidence. See e.g., Brown v. SAIF, 51 Or App 389, 394 (1981). Specifically, a referee's decision to admit an exhibit will be upheld as long as the evidence has some probative value and achieves substantial justice. See Lucke v. Compensation Dept., 254 Or 439, 442-43 (1969).

Therefore, rather than determining whether or not the Referee's admission of the contested evidence violated the Oregon Evidence Code, we review for abuse of discretion. Here, we agree with the Referee that the evidence regarding claimant's prior claim had some relevance to this proceeding. The disputed evidence showed that, having experienced an inguinal hernia, claimant was aware of the symptoms of, and necessary treatment for, such a condition. Such knowledge was relevant to claimant's contention that he did not report his hernia injury or seek treatment for three weeks because he thought he had experienced a "strain" that would resolve without treatment. Therefore, we conclude that the Referee did not abuse his discretion in admitting evidence of the prior claim, and we consider the admitted evidence for purposes of our review.

Compensability

The Referee found that claimant's "21-day delay in reporting his injury strains credulity" in view of his previous hernia injury and claim. Claimant objects to this finding, arguing that we should find him to be a credible witness. Claimant bases this contention on several factors: (1) he asserts that given the results of his first claim proceeding, he would not have "admitted to the three-week delay in reporting," unless he was telling the truth regarding an accident; (2) his lack of motive to be untruthful because he missed no work and is now covered by private health insurance; (3) his promotion from assistant manager to manager subsequent to filing his claim; and, (4) medical reports stating that claimant's injury was work-related.

We first note that although claimant testified that he is now covered by private health insurance, there is no evidence that the medical services necessary to repair his hernia condition are covered under this policy. Furthermore, there is no evidence regarding the employer's reason for promoting claimant or testimony that the employer believed the claim to be credible. Therefore, without such evidence we decline to make the inference urged by claimant that these factors support his credibility.

Moreover, claimant's treating physician, Dr. Loehden, expressly based his opinion that claimant's hernia was work-related on the history provided by claimant. Loehden did not comment regarding claimant's credibility or reliability. We, therefore, find that Loehden's opinion is persuasive only if we find that claimant is credible. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977) (holding that a medical opinion is only as reliable as the patient's history upon which it is based).

Although the Referee found that the three-week delay in reporting the hernia "strained" credulity, he did not make a specific finding regarding claimant's credibility. We, therefore, make our own credibility findings based on the substance of the record. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

Claimant alleges that he injured himself on March 25, 1991, when he lifted a 25-gallon tank filled with propane into the back of a customer's pickup truck. (Tr. 9-10). At that time, claimant allegedly felt a "burning sensation" in his groin area. (Id. at 10). Claimant testified that the sensation was similar to that he experienced with his prior hernia injury. (Id). Claimant's alleged injury was unwitnessed. (Id. at 23). Claimant testified that he completed his shift, went home, felt "sore" and "achey" and noticed a lump about the size of a golf ball in his groin. (Id. at 11). Claimant did not report the injury or seek treatment until April 16, 1991. (Id. at 13).

Claimant further testified that based on his previous hernia injury, he recognized his symptoms as indicating another hernia. (Id. at 18, 27). Claimant's only explanation for the delay in reporting and seeking treatment for the injury, however, is that he thought it was merely a muscle strain that would heal itself. (Id. at 27).

We find claimant's explanation unpersuasive. As previously noted, claimant was aware of the symptoms of a hernia condition. He was also aware that a delay in reporting his injury could adversely affect his claim. From these facts, we conclude that claimant did not credibly testify. Therefore, we also conclude that claimant has failed to prove the compensability of his claim.

ORDER

The Referee's order dated November 7, 1991 is affirmed.

August 27, 1992 Cite as 44 Van Natta 1692 (1992)

In the Matter of the Compensation of
JOHN M. FREEMAN, Claimant
WCB Case No. 91-10314
ORDER ON REVIEW
Charles Robinowitz, Claimant Attorney
Susan D. Ebner (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 current psychological condition. Claimant cross-requests review of that portion of the order that awarded claimant's attorney $2,100 for services rendered in overturning the denial. On review, the issues are medical services 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 conclusions and reasoning as set forth in the Referee's order, with the following supplementation and clarification.

The medical evidence establishes that claimant's current psychological condition is a result of his low back injury and preexisting psychological condition. Because the injury combined with the preexisting condition to prolong disability and need for treatment, the compensability of claimant's current condition is properly analyzed under ORS 656.005(7)(a)(B). Bahman M. Nazari, 43 Van Natta 2368 (1991). Accordingly, claimant bears the burden to prove by a preponderance of the evidence that the compensable injury remains the major contributing cause of his disability and need for treatment. Laverne J. Butler, 43 Van Natta 2454 (1991).

After our review, we agree with the Referee that claimant has carried that burden. When medical evidence is divided, we tend to give greater weight to the conclusions of a claimant's treating physician. Taylor v. SAIF, 75 Or App 583 (1985). In this case, Dr. Grass has examined and treated claimant on an almost regular basis since 1988. He opined that while claimant's underlying personality made him vulnerable to psychological depression, his compensable injury is the major contributing cause of his current condition. He explained:

> "Well, it's fairly cause-and-effect, in my mind. [Claimant] certainly had ups and downs during his life. I think the construction industry is full of that, and he made some money, lost some money, but I don't think there was ever a situation where he was severely depressed or suicidal, couldn't function, lost his ability to sleep or eat or concentrate or write or read, and all of those symptoms really occurred after the injury. They're not symptoms people fake; they're very real, and I think they have a lot to do with his self-concept as a worker, as a person. Certainly he came from a difficult family background. There's [probably a lot of] personality difficulties in that family, some history of depression, history of alcohol abuse, so there's probably some history of vulnerability to depression in [claimant] and many others. But he was coping. He was getting by. He was working. He was doing the best that he could, and that got him through quite a number of years." (Tr. 12).

Because of Dr. Grass's greater opportunity to evaluate claimant's condition, we find his opinion most persuasive and agree with the Referee's conclusion that claimant's industrial injury remains the major contributing cause of his psychological condition. For related reasons, we give less weight to the opinions of Drs. Colbach and Turco, who examined claimant on a very limited basis. See also Weiland v. SAIF, 64 Or App 810 (1983).

Attorney Fees

Claimant challenges the Referee's assessed fee of $2,100 for services rendered in prevailing against SAIF's denial. He contends that an appropriate fee for his attorney's services is $2,700.

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 compensability of claimant's current psychological condition is $2,100, 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 claimant's counsel's statement of services and the hearing record), the complexity of the issue, and the value of the interest involved.

Claimant also is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). Based on similar factors discussed above, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is $1,250, to be paid by the SAIF Corporation.

ORDER

The Referee's order dated December 12, 1991 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $1,250, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
IRWIN W. GEER, Claimant
WCB Case Nos. 92-01980 & 91-17845
SECOND ORDER OF DISMISSAL
Kirkpatrick & Zeitz, Claimant Attorneys
Beers, et al., Defense Attorneys
R. Thomas Gooding (Saif), Defense Attorney

On August 7, 1992, we withdrew our July 23, 1992 Order of Dismissal. We took this action to permit claimant an opportunity to present his position regarding our conclusion that a May 13, 1992 Referee's order had become final by operation of law. Having received claimant's response, we proceed with our reconsideration.

We summarize the relevant facts as follows. The Referee's Opinion and Order issued May 13, 1992. On June 11, 1992, the Referee signed an Order of Abatement. However, the abatement order was not mailed to the parties until June 15, 1992, after the 30-day statutory appeal period had expired. Thereafter, the SAIF Corporation requested Board review. We dismissed the request, reasoning that an abatement order was not a final order. In the alternative, assuming that SAIF was appealing the May 13, 1992 order, we concluded that the order had become final by operation of law.

Following our dismissal order, the Referee issued an Order of Dismissal. Claimant has requested review of that order. Since an abatement order is not a final order, claimant contends that such an order become effective on its signing, not on its mailing. Arguing that the Referee timely abated his May 13, 1992 order, claimant asks that this case be returned to the Referee to proceed with his reconsideration.

As stated in our prior order, 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); Leon C. Buzard, 40 Van Natta 595 (1988). For an order to abate and allow reconsideration of an order issued under ORS 656.289(3), the language of the second order must so state. Farmers Ins. Group v. SAIF, 301 Or 612, 619 (1986).

After conducting our reconsideration, we continue to conclude that an order abating the Referee's May 13, 1992 order did not issue within 30 days of the May 13, 1992 order. Consequently, we adhere to our prior reasoning that the Referee's May 13, 1992 order has become final by operation of law. Accordingly, the requests for Board review must be dismissed.

The following hypothetical illustrates the fallacy of claimant's argument that an abatement order is effective on its execution. A party files his request for Board review within 30 days of a Referee's opinion and order. Unbeknownst to any of the parties, the Referee had signed an abatement order prior to the filing of the appeal. However, because of an oversight, the Referee neglected to mail the abatement order to the parties. Several months later, the Board issues its decision on review of the Referee's Opinion and Order. Thereafter, the Referee discovers the signed abatement order and mails copies to the parties.

Under the theory advanced by claimant, the Board's order would be invalid because the Referee had signed his abatement order prior to the filing of an appeal. Claimant's conclusion would be reached, notwithstanding the fact that the parties had no notice that the abatement order existed until after issuance of the Board's order when the Referee discovered his oversight and mailed copies of the abatement order to the parties. This hypothetical vividly demonstrates that such a theory would

inevitably lead to uncertainty and confusion concerning the appellate procedures for Referee and Board orders, as well as the ultimate validity and finality of such orders.

Consequently, we adhere to our previous conclusion that, in light of the statutory scheme regarding the issuance of Referee and Board orders, an abatement order is not effective until copies are mailed to all parties to the proceeding. We consider such a conclusion to be consistent with a system which is designed to provide notification to all parties to a proceeding through the mails. Such a system keeps each party apprised of ongoing developments concerning the contested case and enables them to determine whether further action is necessary to preserve their rights of appeal.

We further note that our reasoning is in accordance with ORS 183.310(5)(a). The statute defines "order" as any agency action expressed orally or in writing directed to a named person or named persons. The statute further provides that "order" includes any agency determination or decision issued in connection with a contested case proceeding. Id.

Here, the Referee's decision to abate his May 13, 1992 order constitutes a determination in connection with a contested case proceeding. Furthermore, the Referee's abatement order expressly states the Referee's intention to withdraw his May 13, 1992 order for reconsideration. Nevertheless, the Referee's written decision was not "directed to" the parties or "issued" until June 15, 1992, when copies of the abatement order were mailed to all parties to the proceeding. Inasmuch as the 30-day statutory period to alter the Referee's May 13, 1992 order had expired by June 15, 1992, the Referee's abatement order was a nullity.

Our conclusion is likewise consistent with OAR 438-07-025(1), which permits referees to reopen the record and reconsider their decisions provided that no appeal has been filed and that the 30-day appeal period has not expired. As with any formal order, a Referee's decision to reopen the record fro reconsideration is not effective until copies of that decision are mailed to all interested parties.

In conclusion, as recognized in our prior order, it is unfortunate that copies of the Referee's abatement order were not timely mailed to all parties. However, as we have previously explained in Connie A. Martin, 42 Van Natta 495, 853 (1990), the ultimate responsibility for preserving a party's appeal rights must rest with each party.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our July 23, 1992 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

August 27, 1992 Cite as 44 Van Natta 1695 (1992)

In the Matter of the Compensation of
MELVIN D. MANIRE, JR., Claimant
WCB Case Nos. 90-09620, 90-09619 & 90-09618
ORDER On REVIEW
Welch, et al., Claimant Attorneys
Julene Quinn (Saif), Defense Attorney
Roberts, et al., Defense Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation, on behalf of RSG, requests review of that portion of Referee Crumme's order which set aside its denial of surgery at C5-6 on the grounds that the proposed surgery was compensably related to claimant's accepted cervical brachial cephalgia condition. On review, the issues are compensability, responsibility and res judicata. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of paragraph 11 and we add the following supplementation.

On March 1, 1989, SAIF/RSG accepted claimant's claim for cervical brachial cephalgia under claim number 7718013C, and partially denied claimant's degenerative disc condition at C5-6. Claimant requested a hearing on the partial denial, but later withdrew it. The March 1, 1989 partial denial became final by operation of law.

On September 14, 1989, SAIF/RSG denied that claimant's cervical condition was related to its accepted claim for carpal tunnel syndrome under claim number 7006790L. Claimant requested a hearing on the denial, but later withdrew it. This denial became final by operation of law.

ULTIMATE FINDINGS OF FACT

We adopt the Referee's ultimate findings of fact with the exception of the second and third paragraphs and we add the following supplementation.

Claimant's current cervical condition is essentially the same condition which was diagnosed in September 1989.

The only cervical condition denied in relation to claimant's accepted cervical brachial cephalgia claim is degenerative disc disease at C5-6.

CONCLUSIONS OF LAW AND OPINION

Res Judicata

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

The Referee stated that all of claimant's cervical conditions but his cervical brachial cephalgia and a neck strain have been denied. However, SAIF/RSG's September 14, 1989 denial merely denied that claimant's cervical condition was related to its accepted bilateral carpal tunnel claim under claim number 7006790L. The only cervical condition which has been denied in relation to claimant's cervical brachial cephalgia claim, under claim number 7718013C, is his degenerative disc condition at C5-6. Thus, claimant is only barred from contending that his condition at C5-6 is related to his cervical brachial cephalgia claim with RSG/SAIF.

Compensability of C5-6 Disc Herniation

We adopt the conclusions and reasoning concerning the compensability of claimant's C5-6 disc herniation as set forth in the Referee's order.

Compensability of C5-6 Disc Surgery

The Referee concluded that, although claimant's herniated disc at C5-6 was not compensable as to RSG/SAIF because it was barred by res judicata, claimant's proposed surgery for the herniation was compensable. In reaching this conclusion, the Referee relied on Dr. Sirounian's opinion that the cervical brachial cephalgia was directly related to the noncompensable cervical disc herniation. The Referee, therefore, concluded that claimant's cervical disc surgery was necessary to treat claimant's compensable cervical brachial cephalgia (headache) condition under ORS 656.245(1)(a).

Claimant is entitled to medical services for the disabling results of the compensable injury, even if preexisting problems contribute to his disability. Van Blokland v. Oregon Health Sciences University, 87 Or App 694 (1987). If the prescribed medical services constitute an integral part of the total medical treatment for the condition due to the compensable injury, the medical services are compensable. Williams v. Gates McDonald & Co., 300 Or 278 (1985).

For the following reasons, we do not find Dr. Sirounian's opinion sufficient to support compensability of surgery necessary to correct the noncompensable C5-6 disc herniation.

Here, Dr. Sirounian opined only that the accepted cervical brachial cephalgia was directly related to the disc herniation at C5-6. Dr. Sirounian did not state that the surgery is necessitated by the cervical brachial cephalgia. No physician, including Dr. Sirounian, opined that surgery for the C5-6 disc herniation was necessary to treat the cervical brachial cephalgia or would be effective in alleviating claimant's cervical brachial cephalgia.

Accordingly, based on the foregoing reasoning, we conclude that the proposed cervical disc surgery at C5-6 is not compensably related to claimant's cervical brachial cephalgia condition. Therefore, we reverse that portion of the referee's order which had set aside SAIF/RSG's C5-6 surgery denial and awarded a $2,500 attorney fee.

Responsibility

In light of our decision that neither claimant's disc condition at C5-6 nor the C5-6 surgery are compensable, we need not address responsibility.

ORDER

The Referee's order dated June 14, 1991 is reversed in part and affirmed in part. That portion of the Referee's order which set aside SAIF/RSG's denial of surgery at C5-6 is reversed. The $2,500 assessed attorney fee awarded to claimant's counsel for prevailing on the surgery denial is also reversed. The remainder of the Referee's order is affirmed.

August 27, 1992 Cite as 44 Van Natta 1697 (1992)

In the Matter of the Compensation of
WILLIE G. MOSS, Claimant
WCB Case No. 90-18959
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of that portion of Referee Quillinan's order which upheld the self-insured employer's denial of claimant's occupational disease claim for spinal stenosis. The employer cross-requests review of that portion of the Referee's order which set aside its denial insofar as it purported to be a back-up denial of a 1988 claim for spinal stenosis. 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, with the following modification. In lieu of the Referee's third sentence of the first paragraph of the "Findings of Fact" section, we find that there was no significant stenosis at the L3-4 level at the time of claimant's surgery in 1986 (Ex. 79-5), and that a myelogram in November 1987 revealed mild stenosis at L3-4 (Ex. 26). We also adopt the Referee's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

The Referee interpreted the employer's September 23, 1990 denial as being either: (1) a denial of a current spinal stenosis condition; or (2) a "back-up" denial of a 1988 claim for spinal stenosis, which the employer had previously accepted as part of a 1976 low back injury claim. The Referee upheld the denial to the extent it denied a current spinal stenosis condition. However, the Referee set aside the denial to the extent it purported to be a "back-up" denial of the previously accepted 1988 claim for spinal stenosis. We affirm the Referee's order in part and reverse in part, based on the following reasoning.

Claimant asserts that his 1990 occupational disease claim is for his spinal stenosis condition as it existed in September 1988, rather than for a "current" spinal stenosis condition. Claimant seeks to establish the compensability of his September 1988 spinal stenosis condition as an occupational disease, concurrent with but independent from its status as an accepted part of claimant's 1976 low back injury claim. The employer contends that this claim is barred by claim preclusion. We agree.

Claimant initially filed an occupational disease claim in November 1988, alleging low back pain diagnosed on September 20, 1988, caused by repetitive use of his back over many years of employment. (Ex. 43A). On December 30, 1988, the employer denied the occupational disease claim, but accepted the low back condition as part of the 1976 low back injury claim and authorized surgery for decompression of spinal stenosis at L3-4. (Exs. 49, 50). Claimant timely requested a hearing from the denial, but instead of proceeding to hearing, the parties reached a stipulated agreement whereby the employer rescinded its denial and claimant withdrew his request for hearing. However, the parties agreed that the stipulation would not prejudice their future rights or actions in the matter. (Ex. 52).

Following claimant's surgery in December 1988, the employer processed the 1976 injury claim to closure on October 23, 1989. (Ex. 57). Claimant requested a hearing, but challenged only the employer's payment of temporary disability benefits. (Ex. 61). Subsequently, at hearing on May 23, 1990, claimant withdrew, and the Referee dismissed, the hearing request. (Ex. 70). Accordingly, the closure became final. Under these circumstances, we conclude that claimant is barred by claim preclusion from now bringing a claim for the 1988 spinal stenosis condition as an occupational disease. Christopher H. Peppler, 44 Van Natta 856, 857 (1992); see also, Drews v. EBI Companies, 310 Or 134, 149 (1990).

Claimant may, however, file a new claim to establish the compensability of a new and different condition that developed after closure of the earlier claim. Christopher H. Peppler, supra. However, the Referee found, and we agree, that claimant's current spinal stenosis condition is not compensable, since the medical evidence establishes that claimant has not had a spinal stenosis condition since the surgery in December 1988 successfully alleviated the condition. Furthermore, claimant admits that his claim is not for a current stenosis condition at L3-4. Rather, he seeks to have the same stenosis condition that was accepted as part of the 1976 injury claim found to be compensable as an occupational disease. See Appellant's Brief at 2-3. He cannot do so. Christopher H. Peppler, supra; see also, Arthur D. Esgate, 44 Van Natta 875 (1992).

Alternatively, even if we consider the merits of claimant's occupational disease claim, we find that he has not established compensability of his 1988 spinal stenosis condition as an occupational disease. Claimant contends that the work activities over his 30-year work history with the employer were the major contributing cause of the worsening of his congenital L3-4 spinal stenosis condition. We disagree.

Since claimant requested a hearing in this matter after May 1, 1990, and the hearing was convened after July 1, 1990, we apply the 1990 amendments to the Workers' Compensation Law. Or Laws 1990 (Special Session), ch 2, section 54; see Ida M. Walker, 43 Van Natta 1402 (1991).

An "occupational disease" includes any "series of traumatic events or occurrences which requires medical services or results in physical disability or death." ORS 656.802(1)(c). In order to establish the compensability of an occupational disease, claimant must prove his work activities or conditions were the major contributing cause of the disease or its worsening. Id.; ORS 656.802(2). In addition, the existence of the disease must be established by medical evidence supported by objective findings. ORS 656.802(2).

When, as here, multiple causes combine to produce a single disease or condition, it is claimant's burden to prove that his work activities were the major contributing cause of either the onset or the worsening of his underlying condition. Runft v. SAIF, 303 Or 493, 498 (1987); McGarrah v. SAIF, 296 Or 145, 166 (1983); Dethlefs v. Hyster Co., 295 Or 298, 309, 310 (1983).

In determining whether claimant has met the burden of proving that work conditions were the major contributing cause of a disease or condition, we compare employment conditions to non-employment conditions, explanations, or exposures. David K. Boyer, 43 Van Natta 561 (1991), aff'd

mem 111 Or App 666 (1992). We consider all causes of a disease or condition, including those peculiar to the individual, in determining which, if any, was the major contributing cause. Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566, 569 (1991).

Here, the medical evidence is undisputed that several factors caused claimant's spinal stenosis condition, including his congenitally narrow spinal canal, natural and degenerative processes, work activities, his 1976 low back injury and his subsequent surgery in 1986, which was accepted as compensably related to the 1976 injury. The Referee found that claimant's work activities prior to his 1988 surgery were a major contributing cause of his spinal stenosis, which resulted in surgery in 1988. However, in order to establish compensability of the spinal stenosis condition as an occupational disease, claimant must establish that work activities were the major contributing cause of the condition. ORS 656.802(2). We find that claimant failed to carry his burden.

Dr. Bert, claimant's treating orthopedic surgeon, opined in April 1990 that "it is more likely than not that his work activities were a major contributing factor in his degenerative disc disease." However, he also noted that he finds it "difficult to answer whether his work activities played a larger role than other factors." He concluded, "I do feel that his spinal stenosis was a combination of a narrow spinal canal, which was congenital, with a degenerative bulging disc." (Ex. 69).

Responding to claimant's attorney's hypothetical question, Dr. Bert opined that claimant's work activities, as opposed to his off-work activities, were the major contributing cause of the worsening of his spinal stenosis which resulted in surgery in 1988, taking into consideration the factor of normal degeneration, and assuming a baseline level of congenital spinal stenosis. (Ex. 79-9 to -10). However, on cross-examination he stated that considering the multiple factors that contributed to claimant's stenosis condition, including congenital stenosis, work activities, the 1976 back injury, the 1986 surgery, and progressive degenerative factors, he could not state that any one factor contributed more than 50 percent. (Ex. 79-11). Moreover, he agreed that if claimant's work in the last 6-8 years with the employer involved relatively sedentary machine operation, then work activities would play a less important causative role in claimant's need for surgery in 1988, compared to the other factors. (Ex. 79-12). Claimant testified that for his last 6 to 8 years of employment he worked as a planer feeder, a sedentary job that he characterized as "pretty easy." (Tr. 23).

Thus, we find that Dr. Bert's opinions fail to establish that claimant's work activities were the major contributing cause of his 1988 spinal stenosis condition, when compared with all other causal factors. Furthermore, we find that both Dr. Bernstein, who examined claimant in consultation with Dr. Bert and authored an opinion letter in November 1988, and Dr. Whitney, Dr. Bert's partner who authored an opinion letter in February 1991, defer to Dr. Bert's opinion on causation. (Exs. 45, 77).

Moreover, we note that in 1988, Dr. Bert opined that claimant's current L3-4 spinal stenosis was "significantly related" to his 1976 back injury and subsequent surgery in 1986, which was compensably related to the 1976 injury. (Ex. 44; see also Ex. 41). Dr. Bert also stated that claimant's spinal stenosis is progressive and related to his work activity, which Dr. Bert erroneously believed to have been "quite physical" for the past 10 years, whereas claimant actually had worked in the more sedentary job of planer feeder for the 6 to 8 years preceding his surgery in December 1988. Furthermore, Dr. Bert explained that when surgery was performed in 1986, there was no significant spinal stenosis at L3-4, but that the stenosis worsened after the 1986 surgery. (Exs. 79-5, 79-6). Under these circumstances, we cannot conclude that claimant's work activities were the major contributing cause of his spinal stenosis as it existed in September 1988.

The employer cross-appeals that portion of the Referee's order that set aside its denial to the extent it purported to be a "back-up" denial of the previously accepted 1988 spinal stenosis condition. The employer contends, and claimant agrees, that the September 23, 1990 denial was of an occupational disease claim for spinal stenosis in 1988, not a "back-up" denial of the employer's acceptance of the 1988 spinal stenosis condition as part of the 1976 back injury claim. (Ex. 75; see also, Reply/Cross-Respondent's Brief at 4).

We find that there is no ambiguity that the September 23, 1990 denial relates to claimant's occupational disease claim. (Ex. 75). Furthermore, we find no evidence that the employer intended or that claimant understood that the September 23, 1990 letter was a "back-up" denial of the previously

accepted 1988 spinal stenosis condition. The employer had explained its acceptance of the spinal stenosis as part of the 1976 back injury claim, but not as an occupational disease (Ex. 49), had authorized and paid for surgery in December 1988 to correct the L3-4 spinal stenosis, and had processed the Own Motion claim to closure (Ex. 57). Under these circumstances, we find no evidence that the September 23, 1990 denial purported to be a "back-up" denial of the accepted 1988 spinal stenosis condition.

Because we find that there was no "back-up" denial, we reverse those portions of the Referee's order which purported to set aside a "back-up" denial and awarded an assessed attorney fee based on claimant prevailing against the purported "back-up" denial.

ORDER

The Referee's order dated July 23, 1991 is affirmed in part and reversed in part. We reverse those portions of the Referee's order that set aside the employer's September 23, 1990 denial as to the 1988 claim for spinal stenosis and awarded a $2,300 assessed attorney fee. The employer's September 23, 1990 denial is reinstated and upheld in its entirety. The remainder of the Referee's order is affirmed.

August 27, 1992 Cite as 44 Van Natta 1700 (1992)

In the Matter of the Compensation of
YANG G. PARK, Claimant
WCB Case Nos. 91-05856 & 91-03239
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Kinsley, Brazeau, and Hooton.

Claimant requests review of that portion of Referee Menashe's order that declined to award an assessed attorney fee under ORS 656.382(1) in addition to a penalty under ORS 656.262(10)(a) for the insurer's failure to pay temporary disability compensation at the correct rate. On review, the sole issue is attorney fees. We affirm.

FINDING OF FACT

The insurer failed to properly calculate and pay claimant's temporary disability compensation.

ULTIMATE FINDINGS OF FACT

The insurer's failure to pay claimant's temporary disability compensation at the correct rate was unreasonable.

The factual basis for a penalty under ORS 656.262(10)(a) in this case is the same as the factual basis for an attorney fee under ORS 656.382(1).

CONCLUSIONS OF LAW AND OPINION

Since the Referee issued his order, the Court of Appeals has held that a claimant is not entitled to both a penalty under ORS 656.262(10)(a) and an assessed attorney fee under ORS 656.382(1) for the same processing infraction. Martinez v. Dallas Nursing Home, 114 Or App 453 (1992); see also Harry E. Forrester, 43 Van Natta 1480 (1991).

Here, the Referee awarded a penalty under ORS 656.262(10)(a), one-half to be paid to claimant's attorney, for the insurer's resistance to the payment of temporary disability compensation. Inasmuch as the factual basis for the penalty is the same as that for which the attorney fee is sought, claimant is not entitled to an attorney fee under ORS 656.382(1) in this case.

ORDER

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

Board Member Hooton dissenting.

We have determined that a claimant is not entitled to both a penalty under ORS 656.262(10)(a) and an assessed attorney fee under ORS 656.382(1) for the same processing infraction. See Nicolasa Martinez, 43 Van Natta 1638 (1991); Harry E. Forrester, 43 Van Natta 1480 (1991). Those cases, however, do not mandate the majority decision in the present claim.

Here, the Referee awarded a penalty under ORS 656.262(10)(a), one-half to be paid to claimant's attorney, for the insurer's unreasonable failure to increase the payment of temporary disability compensation following receipt of uncontested wage information from claimant. That conduct represents unreasonable delay or refusal and a penalty under ORS 656.262(10)(a) is appropriate.

In addition to the insurer's unreasonable delay in adjusting claimant's temporary disability compensation after receipt of wage information from claimant, however, the insurer or the employer also violated the statutory or administrative rule requirements regulating the investigation and payment of time loss claims. This represents a separate processing infraction for which penalties are also appropriate.

If the employer failed to provide wage information upon request by the insurer, the employer's conduct violates the specific requirements of ORS 656.262(1) and (3). If Liberty Northwest failed to request wage verification or payroll records after notification that claimant disputed the amount of the temporary total disability payment offered by the insurer, Liberty Northwest failed to meet the requirements of OAR 436-60-024(4) which mandates contact with both the employer and the worker and an effort to determine the appropriate wage to forestall disputes on wage related questions that are not readily determined by application of ORS 656.210.

Claimant need not demonstrate which of two possible events actually occurred where, as here, either would result in a determination that the conduct of the parties was in violation of the statutory or administrative processing obligation apart from its simple delay in providing an adjustment. Since either one or both of the employer or Liberty Northwest engaged in conduct that must be characterized as unreasonable resistance to the payment of compensation, apart from the delay already considered and penalized, by refusing to conform to the applicable statutes or rules claimant is entitled to a separate penalty for that separate improper conduct. Because only one penalty of 25 percent may be authorized from amounts then due, and since that penalty has been previously allowed, claimant is entitled to an assessed penalty related attorney fee pursuant to ORS 656.382(1).

The majority improperly focuses only on the final result in its analysis. It concludes that the correct temporary disability payment was delayed or denied, and this constitutes the "processing infraction" and the factual basis of the penalty claim. That is incorrect. The employer/insurer's failure to pay is the end product of two distinct processing infractions, each with its own factual basis. A penalty related attorney fee is appropriate in such a case. In Mollie E. Barrow, 43 Van Natta 617 (1991) we said "[a]lthough a 25 percent penalty may not be assessed for each of [multiple] claims processing violations, there is authority for awarding an attorney fee for each unreasonable claims processing violation regardless of whether any penalty may be assessed". 43 Van Natta @ 618. The recent legislative amendments to ORS 656.262(10) did not disturb our authority to assess a penalty related attorney fee where no penalty could be awarded under ORS 656.262(10). Nicolasa Martinez, 43 Van Natta 1638, 1640 (1991). Therefore, I dissent.

In the Matter of the Compensation of
BILLIE J. PETERSON, Claimant
WCB Case Nos. 91-09147 & 91-08483
ORDER ON RECONSIDERATION
Westmoreland & Shebley, Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

On August 19, 1992, we abated our July 22, 1992 order, which had reversed that portion of a Referee's order that directed the SAIF Corporation to pay claimant's scheduled permanent disability award at the rate of $305 per degree. We took this action to consider the parties' proposed "Stipulation and Order."

The stipulation is designed to resolve all issues raised or raisable in this matter. Specifically, the parties agree that claimant's scheduled permanent disability award shall be paid at a rate of $145 per degree unless and until the issuance of "any final Oregon Supreme Court decision holding that the higher rate [$305 per degree] applies to all awards of permanent scheduled disability made on or after May 7, 1990."

We have approved the parties' stipulation, thereby fully and finally resolving this matter. Accordingly, this matter is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM E. PETTIS, Claimant
WCB Case Nos. 91-08269, 91-08267, 91-08268 & 91-01243
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Charles A. Ringo, Defense Attorney
David Schieber (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Referee Brown's order that: (1) set aside its denial of claimant's claim for a left shoulder condition; and (2) upheld the SAIF Corporation's denial of claimant's claim for the same condition. On review, the issues are compensability and responsibility. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact; however, we do not adopt the Referee's "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant was not in the course and scope of employment with SAIF's insured when his injury occurred. We disagree.

Claimant is a long-haul truck driver who team drives with his wife. On December 3, 1990, claimant's wife finished her five-hour shift of driving. She came back to the "sleeper" to wake claimant for his shift and to sleep. She got into the "sleeper" with claimant. While claimant was attempting to exit the "sleeper" to begin his shift, he dislocated his left shoulder.

In order to be compensable, claimant's injury at SAIF's insured must have occurred within the course and scope of his employment. ORS 656.005(7)(a). The ultimate inquiry is whether the

relationship between the injury and employment is such that the injury should be compensable. Rogers v. SAIF, 289 Or 633 (1985).

We apply the seven factor test adopted by the Court of Appeals to evaluate 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 employee was on a personal mission of his own. While all seven factors are considered, no one factor is dispositive. Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571, 575, rev den 300 Or 249 (1985).

Here, there was clearly a benefit to the employer in having one half of the driving team sleep while the other drove. Thus, the activity benefitted the employer. The activity, sleeping in the sleeper compartment and arising, was contemplated by the employer and the employee. The risk of getting in and out of the sleeper compartment was an ordinary risk of the employment. The record does not indicate whether claimant was paid during the time spent sleeping before his shift began. The activity did not occur on the employer's premises, but did occur in the truck which claimant drove for the employer and in which it was contemplated he would sleep when he was not driving. The employer did not specifically direct the activity, but acquiesced in having its team drivers sleep between shifts. Claimant was not on a personal mission when the injury occurred, but was arising to begin his shift. These factors, taken as a whole, establish that claimant was injured in the course and scope of employment with SAIF.

We also believe that claimant's injury occurred in the course and scope when analyzed under the "travelling employee rule." Under that rule, an employee whose work entails travel away from the employer's premises is held to be within the course and scope of employment continuously during the trip. Such broad coverage is not, however, unlimited. Although a traveling employee will remain covered while engaged in some personal activities such as eating or sleeping, he will not be covered while engaging in other personal activities that are a distinct departure on a personal mission. See Beneficiaries of McBroom v. Chamber of Commerce, 77 Or App 700, 703 (1986); Slaughter v. SAIF, 60 Or App 610, 615 (1982). Here, claimant injured his shoulder while getting up out of the "sleeper" to begin his driving shift; thus, claimant was not engaged in a distinct departure on a personal mission when the injury occurred. Thus, under either the Mellis factors or the travelling employee test, claimant sustained an injury in the course and scope of his employment at SAIF's insured in December 1990. Accordingly, claimant sustained a compensable injury at SAIF's insured.

Responsibility

As a result of the 1990 Special Session, Oregon now has a statute which governs the assignment of responsibility and the shifting of responsibility between successive carriers. ORS 656.308(1). We have interpreted ORS 656.308(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); see also Ronald L. Rushton, 44 Van Natta 124 (1992). Thus, Liberty, as the last carrier against whom claimant had an accepted left shoulder injury, remains presumptively responsible. In order to avoid responsibility, Liberty has the burden to establish that claimant sustained a new compensable injury involving the same condition while working for SAIF's insured.

In order to prove a "new compensable injury," Liberty must show that the 1990 incident was a material contributing cause of disability or need for treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991). The new injury must be established by medical evidence supported by objective findings. See ORS 656.005(7)(a); 656.005(19); Georgia Pacific Corp. v. Ferrer, 114 Or App 471 (1992); Suzanne Robertson, 43 Van Natta 1505 (1991).

We conclude that Liberty has established a new compensable injury involving the same condition. As a result of the December 1990 incident at SAIF's insured, claimant suffered a left shoulder dislocation. Dr. Corson noted objective findings of tenderness in the shoulder, restricted range of motion and, inability to abduct the shoulder to a 90 degree angle. Dr. Corson opined that the December

1990 injury constituted a new injury. Based on this evidence, we conclude that Liberty has met its burden to prove that the December 1990 incident at SAIF's insured was a material contributing cause of claimant's disability and need for treatment. Accordingly, responsibility shifts to SAIF. ORS 656.308(1); Ricardo Vasquez, supra.[1]

Both compensability and responsibility were decided by the Referee. Therefore, by virtue of the Board's de novo review authority, compensability remained at risk on review as well. See Dilworth v. Weyerhaeuser Co., 95 Or App 85 (1989). Consequently, claimant's counsel is entitled to an assessed attorney fee for services on Board review. See Tanya L. Baker, 42 Van Natta 2818 (1990).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $50, to be paid by SAIF, the insurer responsible for the claim. 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 November 19, 1991, as amended November 22, 1991, is reversed. Liberty's denial of responsibility for claimant's left shoulder condition is reinstated and upheld. SAIF's denial of claimant's left shoulder condition is set aside and the claim is remanded to SAIF for processing according to law. The attorney fee awarded to claimant's counsel in the amount of $1,800 shall be paid to claimant's counsel by SAIF, rather than Liberty. For services on review, claimant's counsel is awarded $50, to be paid by SAIF.

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[1] Inasmuch as the parties apparently did not litigate the issue of the compensability of claimant's current condition under ORS 656.005(7)(a)(B) at hearing, we do not address that issue on review.

In the Matter of the Compensation of
RAYMOND L. RASMUSSEN, Claimant
WCB Case No. 90-18111
ORDER OF DISMISSAL
Scheminske & Lyons, Defense Attorneys

The self-insured employer and claimant have moved for dismissal of claimant's former attorney's request for review of Referee Howell's order that declined to grant an attorney fee. On review, the issue whether the Hearings Division has jurisdiction to consider the request. We dismiss the request for review.

FINDINGS OF FACT

Mr. Balocca is claimant's former counsel in this matter. The attorney-client relationship was terminated in late 1991. Following three postponements, this matter was reset for hearing to be held May 7, 1992. On May 5, 1992, claimant and the employer entered into a Disputed Claim Settlement which resolved all issues raised in this matter. The Disputed Claim Settlement was approved on May 8, 1992.

On June 2, 1992, an Order issued withdrawing approval of the Disputed Claim Settlement. The approval was withdrawn in order to allow Mr. Balocca and the employer to submit their positions with regard to Mr. Balocca's entitlement to an attorney fee. On June 24, 1992, the Referee issued an order approving the Disputed Claim Settlement. In the order, the Referee declined to authorize an attorney fee for Mr. Balocca out of the settlement proceeds. Thereafter, Mr. Balocca filed a request for Board review.

CONCLUSIONS OF LAW AND OPINION

Pursuant to ORS 656.283(1), "any party or the director may at any time request a hearing on any

question concerning a claim." Similarly, any party to a Referee's order, may seek Board review of that order. ORS 656.289(3); 656.295(1). "Party" is defined as "a claimant for compensation, the employer of the injured worker at the time of injury and the insurer, if any, of such employer." ORS 656.005(20). Under this provision, "party" does not include attorneys representing a claimant, whether former or not. William G. Rice, 44 Van Natta 182 (1992); Frank F. Pucher, Jr., 41 Van Natta 794 (1989).

Here, Mr. Balocca is claimant's former attorney. As an attorney, he does not qualify as a "party" and, therefore, cannot request a hearing under ORS 656.283(1) or seek Board review under ORS 656.289(3). Thus, regardless of whether Mr. Balocca formally requested a hearing, the Hearings Division lacked jurisdiction to consider Mr. Balocca's request for attorney fees. Rice, supra. Moreover, considering claimant's termination of Mr. Balocca's services, claimant's former attorney lacked authority to appeal the Referee's order. ORS 656.005(20); Wendy S. Reyes, 43 Van Natta 1249 (1991).

Assuming Mr. Balocca did qualify as a party, we would still conclude that neither the Hearings Division nor the Board is the appropriate forum for this dispute. See Timothy S. Waggoner, 43 Van Natta 1856, recon den, 43 Van Natta 2280 (1991). In Waggoner, supra, we found that claimant was entitled to an attorney fee pursuant to ORS 656.386(1) concerning the rescission of the carrier's denial. However, we declined to decide the manner in which the fee should be distributed between claimant's current and former counsel on the basis that it was a matter between the two of them and not the Board. Id. at 1858. See also Fred L. Snider, 43 Van Natta 577 (1991).

Similarly, the instant case involves a dispute involving an attorney fee between claimant and his former counsel. Therefore, this forum is not the appropriate venue for resolution of this matter. Waggoner, supra. In this regard, we note that the Oregon State Bar has an arbitration process available to resolve disputes over attorney fees between attorneys and their clients. Rules of the Oregon State Bar on Arbitration of Fee Disputes, Rule 1.0.

In conclusion, Mr. Balocca does not qualify as a party and therefore could neither request a hearing nor seek Board review concerning this attorney fee dispute. Accordingly, we dismiss his request for Board review.

IT IS SO ORDERED.

August 27, 1992 Cite as 44 Van Natta 1705 (1992)

In the Matter of the Compensation of
RAYMOND J. SEEBACH, Claimant
WCB Case No. 91-02703
ORDER OF ABATEMENT
Merrill Schneider, Claimant Attorney
Roberts, et al., Defense Attorneys

On August 6, 1992, we affirmed those portions of the Referee's order which: (1) directed the insurer to pay temporary disability from August 28, 1990 through September 17, 1990; and (2) assessed a penalty (to be shared equally between claimant and his counsel) based on the aforementioned compensation. Enclosing a December 1991 Disputed Claim Settlement (DCS) approved by a Referee in another WCB Case Number, the insurer seeks withdrawal of our order. Specifically, the insurer asserts that the DCS effectively mooted our review in this case.

In light of these circumstances we withdraw our August 6, 1992 order for reconsideration. Claimant is granted an opportunity to present his position concerning the insurer's request. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
JEANNIE L. SHELTON, Claimant
And, In the Matter of the Complying Status of
JOHN T. and FAY E. JENSEN, Employers
WCB Case Nos. 91-00894 & 90-21423
ORDER ON RECONSIDERATION
Karen M. Werner, Claimant Attorney
David Ray Fowler (Saif), Defense Attorney
O'Neill, et al., Attorneys

On August 14, 1992, we withdrew our July 31, 1992 Order on Review for reconsideration. In our July 31, 1992 order, we found that claimant's injury claim was compensable. Therefore, we reversed the Referee's order which had upheld the SAIF Corporation's denial. In addition, we awarded claimant a $3,000 attorney fee pursuant to ORS 656.386(1) for services at hearing and on review concerning the compensability issue.

Our August 14, 1992 abatement order was issued in response to claimant's request for reconsideration. Specifically, claimant asserted that "the time spent at the hearings level" and the "time expended on the appeal" justified a fee of "not less than $5,200.00." In withdrawing our order, we granted SAIF an opportunity to respond. SAIF has submitted its response, contending that our $3,000 attorney fee award is appropriate. Having received SAIF's response, we proceed with our reconsideration.

After reconsidering the factors set forth in OAR 438-15-010(4) and comparing them to this record, we conclude that a reasonable attorney fee for claimant's counsel's services at hearing and on review is $4,000. In reaching this conclusion, we have particularly considered the time devoted to this case (as represented by: claimant's counsel's April 12, 1991 letter; counsel's introduction of three exhibits at hearing; a 106 page transcript including the testimony from three witnesses; a 20-exhibit record; and claimant's appellant's brief), the value of the interest involved, and the risk that claimant's counsel may go uncompensated. This fee, which is in lieu of the attorney fee granted in our prior order, shall be paid by SAIF on behalf of the noncomplying employer.

Accordingly, on reconsideration, as modified herein, we adhere to and republish our July 31, 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
RICHARD A. STALLING, Claimant
WCB Case No. 91-06267
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Beers, Zimmerman, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Gruber's order that: (1) awarded 42 percent (80.64 degrees) scheduled permanent disability for loss of use or function of claimant's right arm, whereas a Determination Order had awarded 20 percent (38.4 degrees); (2) awarded 38 percent (72.96 degrees) scheduled permanent disability for loss of use or function of claimant's left arm, whereas a Determination Order had awarded 22 percent (42.24 degrees); and (3) directed the insurer to pay these awards at the rate of $305 per degree. In its brief, the insurer argues that the Referee erred in reopening the record to admit evidence assessing claimant's loss of bilateral grip strength. On review, the issues are evidence, extent of scheduled permanent disability and rate of scheduled disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Stipulations" and "Findings of Fact" except for the last two sentences and supplement herein regarding post-hearing events.

CONCLUSIONS OF LAW AND OPINION

Evidence

Prior to claim closure, Evaluation Division sent the insurer an "873" form directing it to "[h]ave Dr. Robertson comment on [claimant's] approximate loss of grip, in percent, as compared to workers age and sex." (Ex. 94). Apparently, Robertson then provided a physical therapist's report listing various grip meter test results. (See Ex. 96). The report did not quantify the test results as losses. (Id). The Division allowed no rating for loss of grip strength. (See Ex. 99).

Claimant requested a hearing seeking an increased scheduled permanent disability award, a higher rate of payment for the award and penalties and attorney fees .

After an August 13, 1991 hearing, the record closed. However, on November 1, 1991, the Referee reopened the record on his own motion. In his Order Reopening the Hearing Record, the Referee stated that, although claimant had established injury-related loss of grip strength, "the information in the record is insufficient to allow any accurate assessment of grip strength loss without conjecture or guesswork in interpreting the meaning of [the evidence]." He therefore found it appropriate to allow claimant to supplement the evidence. Specifically, the Referee stated, "The information required is an assessment of claimant's residual grip strength, in pounds, and an assessment of percentage of retained or lost grip strength in each hand." He allowed claimant 14 days to obtain and submit that information and the insurer 7 days thereafter to inform him of its intention to cross-examine Dr. Robertson regarding any newly-submitted evidence. (Order Reopening the Hearing Record, p. 1).

On November 13, 1991, claimant submitted Exhibits 106 and 107, which the Referee received and admitted. Exhibit 106 is a physical therapist's notation indicating agreement with claimant's counsel's understanding that claimant's residual grip strength is 49 pounds in the right hand and 60 pounds in the left hand. Exhibit 107 is Dr. Robertson's check-the-box response to counsel's query, indicating agreement that the therapist's method "fairly and reasonably represents [claimant's] retained grip strength."

Based on the post-hearing evidence which he solicited, the Referee increased claimant's scheduled permanent disability award. In support of his reopening of the record, the Referee cited OAR 438-07-025(1). That rule, entitled "Reconsideration," provides in relevant part that a "referee may reopen the record and reconsider his or her decision before a request for review is filed or, if none is filed, before the time for requesting review expires. Reconsideration may be upon the referee's own motion. . . ." However, because the rule is limited on its face to reconsiderations of prior decisions, it does not control here. Moreover, even if it did, we would nonetheless conclude that policy considerations dictate that the Referee should not have reopened the record and solicited additional evidence under these circumstances.

In reaching this conclusion, we rely on our recent order in John M. Ames, 44 Van Natta 684 (1992). In that case, a Referee solicited a post-hearing medical report from the claimant's treating physician because the admitted reports did not contain range of motion finding or detailed sensory and motor studies and because a physical therapist's listing of functional limitations could not be used to rate impairment under the standards. We held that, because it is claimant's responsibility to establish the extent and nature of any permanent disability which he or she may have, the Referee should not exercise his or her discretion to cure a basic failure of proof. John M. Ames, supra at 686.

Here, as in Ames, the sufficiency of the record, for purposes of rating impairment under the standards, falls within claimant's area of responsibility under ORS 656.266. The lack of quantifiable evidence concerning claimant's loss of grip strength amounts to a basic failure of proof. (See below). Moreover, in this case, as in Ames, claimant was represented by counsel at hearing. Because the circumstances here are materially similar to those in Ames, the same policy considerations guide us.

Therefore, we conclude that the present Referee should not have reopened the record and, on his own motion, solicited additional evidence in an effort to cure a basic failure of proof. See Ames, supra.

Accordingly, although we have discussed Exhibits 106 & 107 above for the purpose of evaluating post-hearing events, we exclude them for the purpose of rating the extent of claimant's disability.[1]

Extent of scheduled permanent disability

On review, the extent issue is limited to whether claimant is entitled to a rating for lost grip strength under the standards. Claimant argues that, even if the post-hearing reports are not considered, he is entitled to ratings for bilateral loss of grip strength, based on "reasonable inferences." We disagree.

Under former OAR 436-35-110(3)(a), injury-related grip strength loss due to nerve damage is rated according to the percentage loss of function caused by the damage. In this case, although claimant probably has suffered injury-related nerve damage, which in turn caused bilateral loss of grip strength, the record reveals no discernible basis for measuring claimant's loss. See Arlene J. Koitzsch, 44 Van Natta 776, 777 (1992). Because claimant's loss of grip strength cannot be quantified on this record and we decline to estimate his loss, claimant is not entitled to ratings on this basis under the standards. See Paul F. Weigel, 44 Van Natta 44 (1992); James H. Smith, 43 Van Natta 2817 (1991). As we have stated, the defect in the evidence constitutes a basic failure of proof in this case.

Because the Referee addressed only the grip strength issue and no other aspects of the Division's permanent disability award are challenged, we reinstate that award.

Rate of scheduled disability

The Referee concluded that claimant's award of scheduled permanent disability should be paid at the rate of $305 per degree. He relied on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), in which we held that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. Subsequent to the Referee's order, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992).

In this case, claimant was injured on October 20, 1986. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid compensation for his scheduled permanent disability at the rate in effect at the time of his injury. ORS 656.202(2); Former ORS 656.214(2).

ORDER

The Referee's order dated December 2, 1991 is reversed. The Determination Order's permanent disability award is affirmed.

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[1] Although a signatory to the present order, Member Gunn directs the parties' attention to his dissenting opinion in John M. Ames, 44 Van Natta 684, 916 (1992).

In the Matter of the Compensation of
HERIBERTO VALENCIA, Claimant
WCB Case No. 90-08942
ORDER ON REMAND
Michael B. Dye, Claimant Attorney
Garrett, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Valencia v. Bailey Nurseries, 113 Or App 74 (1992). The court has reversed our prior 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 insurer rescinded its denial of chiropractic services prior to hearing. Citing Jones v. OSCI, 108 Or App 230 (1991), the court has reversed and remanded for determination of entitlement to attorney fees.

FINDINGS OF FACT

We adopt the parties' stipulated facts as set forth in the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Relying on our decision in Duane L. Jones, 42 Van Natta 875 (1990), the Referee found that claimant was not entitled to an assessed attorney fee. 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 determination of entitlement to attorney fees.

Here, the insurer argues that its denial was rescinded not because of any action on the part of claimant's attorney, but, because, as the parties stipulated, "the object of the denial (control of chiropractic services) was achieved by the coincident yet independent action of the legislature in enacting Senate Bill 1197." We agree that the rescission of the insurer's denial was prompted by the statutory changes resulting from the 1991 legislature.

However, claimant's attorney filed a request for hearing challenging the insurer's denial of claimant's chiropractic treatment. Furthermore, the parties stipulated that had there not been a request for hearing, the insurer would likely have allowed the denial to become final. Although the request for hearing did not prompt the insurer's rescission of its denial, it did preserve claimant's right to challenge the denial which the insurer concedes it would have allowed to become final absent such a request. Under these circumstances, 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.

In determining a reasonable assessed attorney fee, we consider the factors set forth in OAR 438-15-010(4). After consideration of those factors we find that a reasonable attorney 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 the record), the complexity of the issue, and the risk that claimant's attorney might go uncompensated.

Accordingly, on reconsideration, the Referee's order dated January 25, 1991 is reversed. For services prior to hearing, claimant's attorney is awarded $500, to be paid by the insurer.

IT IS SO ORDERED.

In the Matter of the Compensation of
DONALD S. WADE, Claimant
WCB Case No. 91-00005
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

The SAIF Corporation has requested reconsideration of our June 29, 1992 Order on Review. On July 28, 1992, we abated our order to allow claimant an opportunity to respond.

In our original order, we considered whether or not the Referee correctly ruled that a SAIF investigator's notes of statements obtained from two of claimant's co-workers were subject to disclosure. We found that the purpose of former OAR 438-07-015 was to require full disclosure by both parties of all documents pertaining to a claim; and we found no reason in the facts of this case to hold that full disclosure of the investigator's notes was not required by the rule.

SAIF contends that the order, "when read in conjunction with Booth v. Tektronix, 312 Or 463 (1991), gives the impression that the Board has concluded that the attorney-client and attorney work product privileges are not applicable to proceedings before the Board." Furthermore, SAIF requests that the Board "recognize that both privileges exist within the workers' compensation system, and that the report in this case is privileged as attorney work product."

We grant SAIF's motion for reconsideration. On reconsideration, we hold to our original conclusion that the facts of this case do not implicate, let alone establish, the relevance of the attorney-client privilege or the attorney work product rule. As to the work product rule in particular, we offer the following additional comments.

The SAIF telephone investigator began her investigation when the claim was assigned to her by the claims adjustor, just a few days before she interviewed claimant on January 15, 1991. She interviewed claimant at approximately 5:00 p.m. SAIF denied the claim the next day. On January 18 and 21, 1991, the investigator interviewed the two co-workers in question for the first and only time, about claimant's injury. The co-workers were two of several persons she interviewed as part of her continuing investigation.

At hearing, the investigator did not testify that she had conducted the investigation for SAIF's attorneys, and in preparation for litigation. Rather, she testified that before the denial issued, the claims adjustor requested that she conduct a regular claims investigation and she did so pursuant to that request. What direction she received in and for that investigation was from the claims adjustor.

It is axiomatic that a party seeking to avail itself of the attorney work product rule bears the burden of proving facts which would bring the rule into play. The pertinent historical facts established by this record are as stated above. In lieu of establishing supportive facts, SAIF offers an argument. SAIF contends that "the point where documents become privileged under the work product rule is when the insurer makes a decision that a claim should be denied." (Motion to Reconsider, p. 8). We decline to so rule.

Under the Workers' Compensation Law, an insurer has a continuing duty after a denial is issued to process the claim, and despite a denial, the insurer must even accept the claim where, in the performance of that duty, it obtains information that eviscerates any reasonable doubt that it might have had of its liability for the claim. The failure to rescind a denial in the face of such information exposes the insurer to penalties and other sanctions that the Board or the Director might assess. Here, notwithstanding the timing of the denial, the claims adjustor was conducting a regular claims investigation when she interviewed claimant's co-workers. No SAIF attorney was involved. The Board's rules implement a strong policy preference in favor of full disclosure of the kind of claims processing information involved in this case. Under those rules, issuance of the denial did not transform the written product of that investigation into something that only the insurer had a legitimate interest in and right to see.

Undoubtedly, the work product rule has a legitimate place in an adversarial proceeding.

Whether and to what extent it applies in a workers' compensation case as an exception to the Board rule requiring full disclosure of information relevant to a claim is not a question presented here, since on the facts of this case, it clearly did not apply to the investigative notes at issue.

Lastly, SAIF does not contend that the notes constituted and were withheld as "impeachment evidence" under OAR 438-05-017. Therefore, disclosure in advance of the hearing was required.

On reconsideration, as supplemented herein, we adhere to and republish our June 29, 1992 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
DON M. WILSON, Claimant
WCB Case No. 91-11806
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Charles Cheek (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of Referee Nichols' order that upheld the SAIF Corporation's denial of claimant's left hip 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 found that claimant did not carry his burden of proving his claim compensable with medical evidence supported by objective findings. See ORS 656.005(7)(a). Claimant, relying on Suzanne Robertson, 43 Van Natta 1505 (1991), challenges that conclusion, asserting that he established the compensability of his claim.

In Suzanne Robertson, we found that, in order to satisfy ORS 656.005(7)(a), 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. 43 Van Natta at 1507. That determination may be based on purely objective factors, see ORS 656.005(19), or on the worker's description of the pain 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. Id. Also see Georgia-Pacific Corporation v. Ferrer, 114 Or App 471 (1992).

Here, claimant alleged that, on May 14, 1991, he suffered a fall on the job. Although he saw his family physician, Dr. Morrison, on June 7, 1991, he did not mention a fall or seek treatment for left hip and leg symptoms until August 5, 1991. Claimant saw Dr. Morrison again on August 15.

Dr. Morrison reported that "no abnormal objective findings" were found during the examinations. (Exs. 7, 8). However, Dr. Morrison also stated that claimant "complained of pain in the left hip and leg." (Ex. 7). In view of the fact that Dr. Morrison prescribed medication, offered a tentative diagnosis of back and hip strain, and ordered x-rays of the pelvis and hips, we find that Dr. Morrison indicated that claimant in fact experienced his symptoms and did not merely recite claimant's complaints of pain. Therefore, we find that his report satisfies Suzanne Robertson, supra and Ferrer supra. Furthermore, there is no contradicting medical evidence concerning objective findings.

However, we further find that claimant failed to establish medical causation between any work

accident and his symptoms. We give more weight to those medical opinions which are both well-reasoned and based on complete information. See Somers v. SAIF, 77 Or App 259, 263 (1986).

Here, Dr. Morrison could only state that "it is more probable but not certain that the fall of May 14 contributed to his symptoms. He may have sustained a deep bruise of soft tissues that was slow to resolve." (Ex. 7). Dr. Strukel, medical advisor for SAIF, submitted a conflicting report. He found that Dr. Morrison's possible diagnosis of a deep bruise was unlikely because such a condition would have become symptomatic prior to the August 5 examination. (Ex. 9). Furthermore, Dr. Strukel found that, given the delay in seeking treatment, the lack of purely objective findings, and the results of the x-ray and imaging reports showing normal findings, "it appears that claimant may have fallen, but did not suffer any medically identifiable injury." (Id).

We find that the opinion of Dr. Strukel outweighs that of Dr. Morrison. Dr. Morrison offered no explanation to support his summary statement that claimant's symptoms were attributable to a fall at work. Dr. Strukel's report, on the other hand, offers a well-reasoned explanation to support his opinion that claimant did not suffer a work injury. Therefore, we conclude that the medical evidence fails to prove that claimant compensably injured his left hip and leg.

ORDER

The Referee's order dated December 11, 1991 is affirmed.

In the Matter of the Compensation of
FRANK E. DIEU, Claimant
WCB Case Nos. 91-00117 & 91-00116
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Bottini, et al., Defense Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The self-insured employer, MacDonald Candy Company (MacDonald), requests review of those portions of Referee Davis' order that: (1) set aside its denial of claimant's medical services claim for a low back injury; and (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition. In its brief, SAIF requests review of that portion of the Referee's order which assessed an attorney fee for its denial of compensability. Claimant, in his brief, requests review of those portions of the Referee's order which: (1) assigned responsibility to MacDonald; (2) declined to award an attorney fee on the issue of responsibility; and (3) declined to award a penalty for SAIF's allegedly unreasonable denial of compensability. On review, the issues are compensability, responsibility, 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.

MacDonald accepted a 1967 claim for a low back injury. The "801" form listed the body part affected as "left low back pain and also pain left leg." (Ex. 4). The nature of the injury was described as radiculopathy, S1 and disc protrusions at L4-5. (Exs. 5, 28).

On February 1, 1990, claimant slipped across a wet floor and struck his right shoulder and arm on the wall while working for SAIF's insured. Claimant filled out an incident report that day in which he reported that after the accident he had experienced some discomfort. He further noted on the report that he did not wish to see a physician at that time. Claimant first sought medical treatment for back pain at the emergency room on September 18, 1990.

ULTIMATE FINDINGS OF FACT

The 1990 low back injury with SAIF's insured is a material contributing cause of claimant's disability and need for treatment.

CONCLUSIONS OF LAW AND OPINION

Compensability/Responsibility

The Referee decided this matter under the Workers' Compensation Act, as amended in 1990. We agree; however, we offer the following analysis.

In cases in which an accepted injury is followed by an increase in disability during employment with a later employer/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). Therefore, in the present case, MacDonald, the employer against whom claimant had an accepted low back injury, remains presumptively responsible. In order to avoid responsibility, MacDonald has the burden of establishing that claimant sustained a new compensable injury while working for SAIF's insured. In order to prove a new compensable injury, MacDonald must show that the 1990 injury is a material contributing cause of 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); Georgia-Pacific Corp. v. Ferrer, 114 Or App 471 (1992); Suzanne Robertson, 43 Van Natta 1505 (1991).

On February 1, 1990, while working for SAIF's insured, claimant slipped on a wet floor and struck a wall. As a result of this discrete incident, claimant injured his low back. His treating physician, Dr. Lewis, reported that the 1990 injury was an independent contributing cause of his present degenerative changes at L3-4 and subsequent need for treatment. (Ex. 63A). Therefore, we conclude that the medical evidence, supported by objective findings, establishes that claimant sustained an accidental injury in 1990 that was a material contributing cause of a need for treatment. See ORS 656.005(7)(a). Accordingly, MacDonald has carried its burden of proving the occurrence of a new compensable injury involving claimant's low back condition.

SAIF asserts that, for purposes of determining whether claimant sustained a "new compensable injury" under the amended responsibility law, we must apply ORS 656.005(7)(a)(B). That statute provides:

> "If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or 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."

SAIF argues that: "Based upon the language used in sections 49 and 3 of the new law, the Board should find that Senate Bill 1197 has codified the burden of proof rule as set forth by the [Linda L.] Wise [42 Van Natta 115 (1990)] panel, and increased the quantum of proof required to major contributing cause." We disagree.

In Rosalie S. Drews, 44 Van Natta 1091 (1992), we held 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. Therefore, ORS 656.005(7)(a)(B) is not applicable in the responsibility context. See also Bahman M. Nazari, 43 Van Natta 2368 (1991).

Accordingly, it is not MacDonald's burden to establish that the 1990 injury was the major contributing cause of claimant's condition. Its burden went no further than proving material contributing causation in order to establish a new compensable injury. MacDonald carried its burden of proof and responsibility for the claim shifts to SAIF. SAIF must accept responsibility for the claim and process it.

Unreasonable Denial

A penalty is assessable under ORS 656.262(10) if an insurer "unreasonably delays or unreasonable 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 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, SAIF denied the claim on the basis of both responsibility and compensability. In regard to compensability, SAIF based its denial on the contention that claimant's preexisting conditions were the cause of his need for treatment. Given the evidence in the record, we believe that SAIF's denial of compensability was without any legitimate basis.

All of the medical evidence available to SAIF prior to its denial, indicated that claimant's current need for treatment was either attributable to his 1967 compensable injury and subsequent surgeries, or the February 1990 fall at work, or a combination of both. Therefore, the only genuine question in dispute at the time of SAIF's denial, was which work-related event, and thus, which employer, was responsible for claimant's disability and need for treatment.

Therefore, at the time of its denial, SAIF did not have a legitimate doubt of compensability in regard to claimant's disability and need for surgery. See Harold R. Borron, 44 Van Natta 1579 (1992). Accordingly, for the above reasons, we find that SAIF's denial was unreasonable. SAIF is assessed a penalty of 25 percent of the amounts "then due" as of the date of hearing as a result of this order. One-half of the additional amount shall be awarded to claimant's attorney, in lieu of an attorney fee. See ORS 656.262(10); Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

Attorney Fees - Hearing/Board

Inasmuch as claimant has finally prevailed against SAIF's denial of compensation, he is entitled to an attorney fee award for services at hearing and on Board review. ORS 656.386(1). In light of such circumstances, it is unnecessary for us to address claimant's contention that the Referee erred in failing to award claimant an attorney fee on the issue of responsibility to be paid by McDonald.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that reasonable fees for claimant's attorney's services at hearing is $1,900 (as previously awarded by the Referee) and on review is $560, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 7, 1991 is affirmed in part and reversed in part. That portion of the order which set aside the responsibility denial of MacDonald, the self-insured employer, and upheld the SAIF Corporation's denial is reversed. MacDonald's denial is reinstated and upheld. SAIF's denial is set aside and the claim is remanded to SAIF for processing according to law. For SAIF's unreasonable denial, claimant is awarded a penalty equal to 25 percent of the compensation due as of the date of hearing as a result of this order, payable by SAIF. This penalty shall be paid in equal shares to claimant and his attorney. The remainder of the order is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $560, to be paid by SAIF.

In the Matter of the Compensation of
JANNETTE A. KELLY, Claimant
WCB Case No. 91-11023
ORDER ON REVIEW
Philip Schuster II, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Neal's order that increased claimant's unscheduled permanent disability award for an upper back injury from 7 percent (22.4 degrees), as awarded by a Determination Order, to 10 percent (32 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. In October 1990, the employer presented a job description to Dr. Mead, claimant's treating D.O., for her opinion as to whether claimant was released to perform that job. (Ex. 39). In response, Dr. Mead listed several modifications to this job description. The employer did not subsequently offer the job, as modified by Dr. Mead, to claimant.

Dr. Mead neither measured claimant's cervical ranges of motion nor ratified any measurements of ranges of motion taken by another health care professional.

CONCLUSIONS OF LAW AND OPINION

Because claimant became medically stationary before July 1, 1990, the disability standards which became effective January 1, 1989 (WCD Admin. Order 6-1988) must be applied in rating her disability. OAR 436-35-003(1). Accordingly, we apply former OAR 436-35-270 through 436-35-440 to the rating of claimant's unscheduled permanent disability. WCD Admin. Order 6-1988. These are the standards applied by the Referee.

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, skills and training. Former OAR 436-35-300(6). Once determined, the values for age and education are added. The sum is then multiplied by the appropriate adaptability value. The product of those values is added to the impairment value, and any fractional number is rounded to the next whole number. This yields the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

The parties agree that claimant's value for age is 0 and her value for education is 5. Claimant disputes the values assigned by the Referee for adaptability and impairment.

Adaptability

The Referee determined that claimant had turned down a work offer by the employer that had been approved by the physical capacity evaluator. On that basis, the Referee rated claimant's adaptability as 1 using the matrix at former OAR 436-35-310(3).

Claimant argues that the job offer was not a valid work offer because it was neither approved by her attending physician nor delivered in a manner required by the standards. Therefore, claimant argues, her adaptability value should be determined pursuant to former OAR 436-35-031(4). We agree with claimant.

An adaptability value for a claimant who is unable to return to his or her usual and customary work but who has returned to, or received a "work offer" for, modified work is determined from a matrix of values at former OAR 436-35-310(3). Pursuant to former OAR 436-35-270(3)(d), a "work offer"

as used in former OAR 436-35-310 means delivery in person or by certified mail, return receipt requested, of a written offer of work by the employer to which there is a physician's release. A "physician's release" refers to a release by claimant's "attending physician" and "means the doctor has agreed that the worker is physically capable of performing a job that the employer has offered to the worker." Former OAR 436-35-270(3)(c).

Here, the work offer was transmitted to claimant by means not in evidence. We conclude, therefore, that the employer has failed to establish that the work offer was transmitted by certified mail or in person. Juel L. Fadness, 43 Van Natta 520 (1991), Debbie L. Muse, 43 Van Natta 184 (1991).

In addition, we find that claimant's attending physician did not release claimant to perform the job described by the employer. The employer submitted a job description entitled "Laminator: Photofinishing Laboratory" to Dr. Mead for her approval. (Ex. 39). Dr. Mead marked the box indicating that claimant was "released for [the] above job, as described." Id. However, Dr. Mead's release contained the following conditions:

> "(1) 6 hours per day trial basis only;
>
> (2) Breaks as outlined above are mandatory;
>
> (3) The pt. should be [illegible] w/in 2 wks to assess tolerance;
>
> (4) Consider job site visit by ergonomic/bio trained nurse for possible modification [illegible].
>
> On her FCE [Functional Capacities Evaluation] this patient was only able to lift knuckle to shoulder 17 times [secondary] to back pain & so "frequent" lifting & reaching may not be tolerated well. This patient should be seeking employment that does not involve this degree of repetitive motion of the upper extremities." (emphasis in original) (Ex. 39).

Given this list of conditions, especially the limit to less than eight hours of work per day, we find that the job that Dr. Mead approved was not the job the employer offered. Furthermore, the record does not indicate that the employer subsequently offered claimant the job as modified by Dr. Mead's conditions. Accordingly, we conclude that the offer is not a valid "work offer" for purposes of determining adaptability pursuant to former OAR 436-35-310. Because claimant has neither returned to modified work nor received a "work offer" for such work, former OAR 436-35-310(3) does not apply in this case.

An adaptability value for a claimant who is unable to return to his or her usual and customary work and who has not returned to modified work is determined by the claimant's residual physical capacity, without regard to that claimant's physical capacity prior to the injury. Former OAR 436-35-310(4).

Claimant is unable to return to her usual and customary work and has not returned to, or been offered, modified work since she became medically stationary. Claimant's physical capacity falls within the light category. Thus, the appropriate adaptability value is 4. Former OAR 436-35-310(4)(c).

Impairment

The Referee concluded, the parties do not dispute, and we conclude that claimant is entitled to an impairment value of 5 percent for a chronic condition limiting repetitive use of her neck. Claimant contends that she is also entitled to an impairment value for loss of range of motion in her neck.

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 (Special Session), ch. 2, §54(3); Stephen A. Roberts, 43 Van Natta 1815 (1991).

Section 54(3) of the 1990 Law 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 worker's impairment for the purpose of evaluating the worker's 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 worker's impairment. Glenda D. Kenna, 44 Van Natta 1238 (1992); Dennis E. Conner, 43 Van Natta 2799 (1991).

Here, Dr. Mead, the attending physician at the time of claim closure, did not provide any range of motion measurements after claimant became medically stationary. Although it is sufficient for the attending physician to ratify impairment measurements taken by others, Dr. Mead did not do that either. The closest Dr. Mead comes to ratification of another's impairment measurements is her general statement that the July 1990 functional capacities exam was more accurate than the December 1990 examination performed by Dr. Laycoe, examining orthopedist. (Ex. 46). This July 1990 functional capacities exam did not provide any range of motion measurements. (Ex. 33-2). Instead, it reported that claimant had "no significant limitations or restrictions in spinal range of motion." Id. On this record, claimant has not established any loss of range of motion. Therefore, her total impairment value is 5 percent for a chronic condition limiting repetitive use of her neck.

Computation of Disability

Having determined each of the values necessary under the "standards," claimant's unscheduled permanent disability may be calculated. The sum of the value for claimant's age (0) and the value for claimant's education (5) is 5. The product of that value and the value for claimant's adaptability (4) is 20. The sum of that product and the value (5 percent) for claimant's impairment is 25 percent. Therefore, claimant's unscheduled permanent disability under the "standards" is 25 percent.

Permanent Disability Outside the Standards

Either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by claimant is more or less than the entitlement indicated by the standards. Or Laws 1990 (Special Session), ch. 2, §54(3); former ORS 656.283(7) and 656.295(5). To be clear and convincing, evidence must establish the truth of the asserted fact as "highly probable." Riley Hill General Contractor v. Tandy Corporation, 303 Or 390, 402 (1987).

Claimant argues that, based on range of motion findings not ratified by her attending physician, she has established by clear and convincing evidence that her disability exceeds the value provided by the standards. However, the only range of motion findings "ratified" by the attending physician indicate "no significant limitations or restrictions in spinal range of motion." (Ex. 33-2, 46). Under these circumstances, we do not find it "highly probable" that the record as a whole establishes that claimant's permanent partial disability exceeds that indicated by the standards. Absent clear and convincing evidence, we conclude that the standards correctly compensate claimant for her injury.

ORDER

The Referee's order dated November 18, 1991, as amended December 2, 1991, is modified. In addition to the Referee's and Determination Order awards totalling 10 percent (32 degrees), claimant is awarded 15 percent (48 degrees) unscheduled permanent disability, giving her a total award to date of 25 percent (80 degrees) unscheduled permanent disability for an upper back injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney by the insurer. However, the total attorney fee award granted by the Referee and Board order shall not exceed $3,800.

In the Matter of the Compensation of
TED W. PECKHAM, Claimant
WCB Case No. 90-21377
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Mongrain's order that upheld the insurer's denial of claimant's aggravation claim for a back condition. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We agree with the Referee that claimant failed to prove a worsened condition with medical evidence supported by objective findings, as required by ORS 656.273(1). Dr. Potter, claimant's treating orthopedic surgeon, documented muscle spasm and tenderness in claimant's low back. (Ex. 74-2). Initially, Dr. Potter attributed such findings to "a general worsening" of claimant's condition. (Ex. 76-1). However, Dr. Potter subsequently retracted his opinion after an MRI showed no evidence of a central disc and claimant reported symptoms following the MRI indicating significant overlay. (Ex. 82). Dr. Potter concluded that claimant's condition had not worsened. (Id).

Because Dr. Potter's subsequent opinion is based on more information than his initial opinion, we give it more weight. See Somers v. SAIF, 77 Or App 259, 263 (1986). Dr. Potter's opinion clearly fails to support a worsening of claimant's condition. Having failed to prove a worsening of his condition with medical evidence, we conclude that the findings of muscle spasm and tenderness are not evidence of aggravation. To the contrary, Dr. Potter attributed claimant's muscle spasm to weak structural muscles, poor posture and obesity. (Ex. 83-44). There was also evidence that claimant's symptoms were due to functional overlay. (Exs. 77-8, 82).

Without medical evidence supported by objective findings proving a worsening, claimant's aggravation claim must fail.

ORDER

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

In the Matter of the Compensation of
WILLIAM W. PLEMMONS, Claimant
WCB Case No. 90-08549
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Westerband, Moller, and Gunn.

The SAIF Corporation requests review of that portion of Referee Davis' order that granted claimant permanent total disability, whereas a Determination Order found that his permanent disability had decreased, and awarded claimant 19 percent (60.8 degrees) unscheduled permanent disability. Claimant cross-requests review of that portion of the order that found that he was entitled to permanent total disability as of the date of hearing. On review, the issue is extent of unscheduled permanent disability, up to and including permanent total disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," with the exception of the fourth paragraph on page six of his order.

CONCLUSIONS OF LAW AND OPINION

Permanent Total Disability

The Referee concluded that claimant was permanently and totally disabled. We disagree.

At the outset, we note that the parties do not dispute the Referee's conclusion that the Evaluation Section had no authority to alter claimant's prior award of unscheduled permanent disability which had become final as a matter of law. Moreover, we agree with the Referee's conclusion and find that any attempt by the Evaluation Section to reduce claimant's prior award would be invalid. Therefore, we find that the Determination Order, in effect, declined to award permanent disability beyond the 90 percent claimant had been previously awarded. See Randy Strazi, 42 Van Natta 1116 (1990). Accordingly, we find that claimant's last award of compensation was the 1987 Opinion and Order which awarded him 90 percent unscheduled permanent disability.

In order to receive an increased award of permanent disability, claimant must establish that his compensable condition has permanently worsened since the last arrangement of compensation, which in this case is the October 9, 1987 award of 90 percent unscheduled permanent disability. Stepp v. SAIF, 304 Or 375 (1987).

We are not persuaded that claimant has established that his condition has permanently worsened. At the time of claimant's last award of compensation in 1987, Dr. Kuttner, M.D., reported that claimant had only "sporadic" healthy days and that he considered claimant to be permanently and totally disabled due to his physical limitations. Additionally, claimant's treating neurologist, Dr. Lafrance, agreed with Dr. Kuttner and reported that claimant had "variability of his pain and a very low threshold for precipitation of long-standing exacerbation of pain on an almost daily basis," which would continue "to prohibit him from employment in a normal job market." Finally, at the time of the 1987 hearing, claimant testified that he was unable to sit, stand or walk for any extended period of time. He further testified that there was no work that he felt capable of performing for an eight-hour day.

Prior to the 1991 hearing, Dr. Lafrance testified that claimant had worsened since october 1987. Dr. Lafrance based his opinion upon claimant's cervical condition and subsequent surgery, and he opined that claimant had an overall worsening of headache and neck pain. Dr. Lafrance reported that claimant was limited in regard to activities and could only sit, stand and walk in increments of a half hour or less. He further reported that claimant could not push, pull or work with his arms extended or overhead.

We do not find that Dr. Lafrance's opinion establishes a permanent worsening of claimant's

condition since the time of the 1987 award of compensation. Both Dr. Kuttner and Dr. Lafrance initially reported that claimant's impairment limited his abilities and precluded him from working. We conclude that Dr. Lafrance's subsequent report provides substantially the same information and reiterates similar limitations. Finally, claimant testified at the 1991 hearing that, although there were some areas that were a little different or worse than before, his condition in 1987 "was fairly basically the same as it is now." (Tr. 146).

Accordingly, because we do not find that claimant's physical condition has permanently worsened or that his ability to work has been permanently diminished since October 1987, claimant is not entitled to receive an increased award of permanent disability.

Moreover, we conclude that, even if claimant were able to establish a worsening of his condition, we would nonetheless find that he has failed to establish an entitlement to permanent total disability.

The Referee found that claimant had not actively sought employment outside his own furniture and repair business. The Referee noted that claimant had contacted only one potential employer in the past two-and-a-half years.

One of the elements of establishing entitlement to an award of permanent total disability is a requirement that, unless claimant's physical incapacity in conjunction with his nonmedical disabilities renders a work search futile, he must also establish that he has made reasonable efforts to obtain such employment. ORS 656.206(3); SAIF v. Scholl, 92 Or App 594 (1988). Even if a work search would be futile, claimant must nevertheless prove that, but for the compensable injury, he is willing to work. SAIF v. Stephen, 308 Or 41 (1989).

We first conclude that claimant's contact of one potential employer in the past two years does not constitute a reasonable effort to obtain employment. Furthermore, although Dr. Lafrance has implied that it would be futile for claimant to seek work, at hearing, claimant testified that he did not participate in an on-the-job evaluation or vocational assistance because he "did not want to wreck his shop work." (Tr. 179). Claimant also testified that he may have told the vocational counselor that he needed more pay than the jobs of hotel clerk and retail sales could provide. (Tr.217). Under the circumstances, we conclude that claimant has not established that, but for his compensable injury, he would be willing to seek work.

Finally, claimant testified that he has his own small business repairing furniture, although he only earned approximately one hundred dollars a month performing such work. However, the court has held that where a claimant is capable of working on a part-time basis and such work is available, we must find that the claimant is capable of remunerative, and therefore, gainful employment. See Tee v. Albertsons, Inc., 107 Or App 638 (1991). Accordingly, because claimant has his own business and receives remuneration for his repair services, we find that he is not permanently and totally disabled. Cf. Carol I. Knapp, 44 Van Natta 719 (1992) (claimant's photography activities not gainful employment where undertaken primarily as a hobby and claimant had not received remuneration).

For the aforementioned reasons, we conclude that claimant has failed to establish that he is entitled to an award of permanent total disability. We, therefore, reverse the Referee on that issue.

Extent of Unscheduled Permanent Disability

Because we have above concluded that claimant has not shown a permanent worsening of his condition from the time of the 1987 award of compensation, we find that he is not entitled to additional unscheduled permanent disability.

ORDER

The Referee's order dated July 23, 1991 is reversed. The March 13, 1990 Determination Order is affirmed to the extent that it declined to award permanent disability beyond the 90 percent (288 degrees) unscheduled permanent disability previously awarded.

Board member Gunn dissenting.

I disagree with the majority that there is insufficient or no evidence that claimant has worsened since his last arrangement of compensation in March 1987. The Referee, who heard all the testimony and actually observed claimant, concluded that claimant's condition had worsened. See Opinion and Order at 8. Further, the record contains medical evidence and medical and lay testimony supporting a finding that claimant has permanently worsened since 1987. Therefore, inasmuch as a preponderance of the evidence supports a finding that claimant's condition had worsened, I can only assume that the majority seeks to impose a higher level of proof in the present case.

The threshold requirement to recover increased permanent disability is a greater permanent injury than formerly existed. Stepp v. SAIF, 304 Or 375, 381 (1987). Specifically, we first compare claimant's present medical condition with the condition at the time of the earlier award or arrangement of compensation. If that condition is unchanged or improved, there has been no worsening. Stepp v. SAIF, supra.

Here, claimant's condition has not changed and it has not improved. Thus, I would conclude that he has sustained a worsening. Indeed, given the severity of claimant's injuries, his multiple surgeries and level of pain, the worsening may have to be measured with judicial micrometers. However, Stepp v. SAIF only requires a finding of an increased permanent worsening from the last arrangement of compensation, not a specific quantitated amount of worsening. Similarly, inasmuch as ORS 656.005(7)(a) does not require a specific "quantum" of "objective findings," neither ought claimant here be required to establish more than a worsening. Accordingly, even if claimant were to have permanently worsened, only by a nanodegree, he would satisfy my requirements and that, I believe, of the law.

Alternatively, I disagree with the Court's holding in Stepp that an aggravation claim that provides an opportunity to argue extent of disability is relitigation of the same issue from the previous claim. Although an aggravation claim flows from the original compensable injury, it is a separate claim for a separate condition and not a relitigation. Under the new law (SB 1197), to sustain an aggravation requires that the claimant show that his/her condition is not more than a waxing and waning of symptoms of the condition contemplated by the previous permanent disability award. ORS 656.273(8). Under new law, a worsening is not presumed even if the claimant has inpatient treatment of a condition from the original injury. ORS 656.273(1)(b). Any legal linkage between original injury claims and aggravation claims has been rent asunder by SB 1197. Thus, the application of Stepp is no longer valid. Accordingly, I would hold that claimant is not required to prove that his physical condition has worsened since the last arrangement of compensation.

Nevertheless, in the present case, I would find that either claimant has sustained an increased permanent worsening from his last arrangement of compensation and/or is permanently and totally disabled as contemplated in ORS 656.206(1)(a). Assuming that my legal arguments or the evidence can sustain the hurdle of Stepp v. SAIF, I turn now to the majority's second legal conclusion.

At issue is the following inquiry. Does part-time (if one half-hour or less a day qualifies as part-time) self-employment in furniture repair constitute "gainful employment?" The majority answers this question in the affirmative, relying upon Tee v. Albertsons, Inc., 107 Or App 638 (1991).

When I first read Tee v. Albertsons, Inc. I was reminded of a line from the movie, "Tom Horn." In the movie, Tom Horn (who actually lived and was hung for this crime) was asked if he had shot a fourteen year old sheepherder from over six hundred yards. He replied, "If I did it was the meanest thing I've ever done and the best shot I've ever made."

I am sure that the majority took their best shot at interpretation of the law. Unfortunately, the fatality here, is the rights of injured workers. The present case is an example of the concern expressed by the dissent in Tee v. Albertsons Inc., supra, Justice Rossman, dissenting, stated:

> "The majority holds that the Board did not err in concluding that, because claimant is employable in jobs earning only one-third of her pre-injury wages, she is

'gainfully' employable and is therefore, ineligible for permanent total disability (PTD) benefits. I disagree.

"* * * * *

"I am especially concerned with today's holding because -- assuming that there actually is a market for it -- the telemarketing job might be used to deny PTD benefits in all cases, because the inference is that almost anyone, regardless of physical disability can perform it. If that comes to pass, it will be because the majority has effectively eviscerated the term 'gainful' from the statute." Tee v. Albertsons, supra at 642-43.

In the instant case, claimant can work from 5 minutes to 30 minutes a day in his wood working shop. For this activity, he has earned approximately $100.00 a month. Assuming a seven day work week, claimant can work up to 182 hours a year. Therefore, considering that a full time employee works 2,080 hours a year and a part time employee provides 1,040 hours of work, I am unaware of any employment in a hypothetical or real labor market that would only require, at full capacity, a 30 minute workday from an employee.

Professor Larson aptly states:

"The determination of permanent total disability 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, Workmen's Compensation Law 10-101, 57.21 (1986). See also Harris v. SAIF, 292 Or 683 (1982).

Although claimant can perform wood working projects in his shop at home, his potential for work realistically falls into the category of "distortions" discussed by Professor Larson above. The true test is not whether claimant can earn money. The test is whether claimant is employable. For claimant, here, to be employable, he would have to be able to find an employer with a sedentary job who would be willing to accept 5 to 30 minutes of work from claimant a day, and who would understand absences from work due to his condition, who would be willing to allow claimant to take rest periods at will throughout the day, who would not require claimant to finish projects within set deadlines.

Under the circumstances, I can only conclude that claimant is able to perform his wood working projects due to his continuing strong motivation combined with a work situation (a shop in his own home) tailored to his specific physical needs. Were it not for claimant's special home situation, claimant's condition renders him in essence unemployable. See Harman v. SAIF, 71 Or App 724 (1985) (had it not been for a combination of strong motivation and a job specially tailored to claimant's specific physical needs, claimant would have been virtually unemployable; thus, claimant has established that he is permanently and totally disabled).

Further, I find the present case distinguishable from Tee and because of this, I believe, the majority's reliance on Tee is erroneous. In Tee, the claimant was found to be employable. The telemarketing job offered the claimant regular work. There existed a labor market for part-time telemarketers.

In contrast, it is obvious that claimant is not employable. He cannot perform a service on a regular basis. Moreover, I can think of no labor market that provides for sub-part time furniture refinishers.

Hence, we would be taking an overreaching leap of blind faith, were we to presume there existed a supply of saint-like employers who would understand that due to pain or injury, an employee might not be able to work that day or that hour. With technology and the loss of America's industrial base, there are many service type employments that anyone can do at any given time. However, the question is, can claimant regularly perform that work sufficiently to provide himself/herself with a fair, sufficing and reasonable income? Or is $1,200 a year "gainful" employment? It should be a given that the answer to both questions, in the instant case, is no.

I note that Webster's defines "gainful" as "producing gain; profitable." See Webster's New World Dictionary, 570 (2nd ed 1982). Further, common usage synonyms for "gainful" are: advantageous, good, lucrative. Therefore, I would suggest that until the legislature opts to, if ever, replace the usage of "gainful" with "destitute" employment, that the majority's holding has effectively introduced poverty as a benefit in the Workers' Compensation Law.

Finally, the majority concludes that claimant has not made reasonable efforts to obtain employment. The Referee found, as do I, that claimant's willingness to work was evidenced by his self-employment efforts. Moreover, I refer the majority to Carol J. Knapp, 44 Van Natta 719 (1992).

In Carol J. Knapp, supra, the claimant had done photography as a hobby. Further, she had also prepared business cards, was anticipating photographing two weddings at the time of the hearing, was 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. In Knapp, we found that the claimant's photography activity did not constitute regular, gainful and suitable work. We also found that her photography activity was evidence of the claimant's willingness to work or to seek work within the constraints of her physical limitations.

It is clear from my discussion above and the medical evidence and even prior Board opinions, that any formal work search would have been futile. Thus, I would agree with the conclusions of the Referee and would affirm and adopt the Opinion and Order.

In sum, claimant's burden of proof, is just that, a burden. However, it has never meant to be an unobtainable task or require an evidentiary weight so great, that none could carry it. Accordingly, I dissent.

In the Matter of the Compensation of
CAMERON D. SCOTT, Claimant
WCB Case No. 91-13685
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Barber's order that: (1) declined to award a penalty or related-attorney fee for the self-insured employer's allegedly unreasonable failure to timely process claimant's aggravation claim; and (2) declined to award a penalty or related-attorney fee for the employer's allegedly late payment of time loss compensation. In its brief, the employer requests review of that portion of the order that awarded an assessed attorney fee of $1250 for claimant's counsel's services in connection with the employer's pre-hearing rescission of the "de facto" denial of claimant's aggravation claim. Claimant moves to strike that portion of the employer's respondent's brief which argues that claimant is not entitled to the latter fee under ORS 656.386(1). On review, the issues are the motion to strike and penalties and attorney fees. We deny the motion to strike, reverse in part and affirm in part.

FINDINGS OF FACT

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

The employer did not accept or deny claimant's aggravation claim within 90 days of notice of that claim.

Claimant's counsel was instrumental in obtaining compensation for claimant without a hearing, by virtue of his efforts on claimant's behalf prior to the employer's rescission of its "de facto" denial of the aggravation claim.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant has moved to strike the portion of the employer's respondent's brief which contends that he is not entitled to an attorney fee under ORS 656.386(1), because the employer did not file a formal cross-appeal concerning that issue. However, we have previously held that we have authority to consider issues which are not raised via formal cross-requests for review. Kenneth Privatsky, 38 Van Natta 1015 (1986). Accordingly, claimant's motion is denied.

Penalties

Penalties or attorney fees may be assessed when a carrier "unreasonable delays or unreasonably refuses to pay compensation." ORS 656.262(10); 656.382(1). The reasonableness of a carrier's action must be gauged based upon the information available to the carrier at the time of its action. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

Interim Compensation

The Referee concluded that the insurer's allegedly untimely payment of interim compensation was not unreasonable. We agree.

Dr. McKillop's June 17, 1991 letter, which the employer received on June 21, 1991, (Ex. 2), constituted an aggravation claim. See Herman M. Carlson, 43 Van Natta 963 (1991). Although Dr. McKillop's June 17, 1991 letter contained all the elements of a "compensable worsening" under ORS 656.273, it also expressed willingness to allow claimant to continue working. (Ex. 2-2). Because the letter did not provide medical verification of claimant's inability to work, it did not trigger the employer's duty to pay interim compensation. See ORS 656.262(4)(a).

Dr. McKillop's October 9, 1991 letter did authorize time loss beginning the day claimant stopped working for the employer. However, although employer's counsel referred to his date-stamped copy of the October letter (see Tr. 23), there is no evidence as to when the employer received that letter. Because we are unable to determine, on the record, when the employer received notice of claimant's inability to work due to his worsened condition, we cannot say that the employer's duty to pay interim compensation was triggered more than 14 days prior to its payment of that compensation. See ORS 656.262(4)(c). Accordingly, we do not find the employer's payment of interim compensation unreasonable. Therefore, a penalty or related-attorney fee is not warranted.

Failure to Process

As noted above, Dr. McKillop's June 17, 1991 letter did constitute a claim for aggravation. On its face, the employer's September 27, 1991 Notice of Acceptance establishes that the claim was neither accepted nor denied within 90 days, as required by ORS 656.262(6). The employer's untimely processing of the claim amounts to a "de facto" denial of that claim. See Barr v. EBI Companies, 88 Or App 132 (1987). Because the employer's tardy response is unexplained, it is unreasonable. See Lester v. Weyerhaeuser, 70 Or App 307, 312 (1984). Such conduct supports a penalty, if there are amounts "then due" during the delay period. See ORS 656.262(10); Wacker Siltronic Corporation v. Satcher, 91 Or App 654, 658 (1988). There is no evidence of lost wages or unpaid medical bills under this claim.

Consequently, claimant has not proven that there were amounts "then due," supporting a penalty in this case. See Wacker Siltronic Corporation v. Satcher, supra; Jeffrey D. Dennis 43 Van Natta 857, 858 (1991).

Nevertheless, ORS 656.382(1) warrants an attorney fee when a carrier engages in conduct which constitutes unreasonable resistance to the payment of compensation, when there are no amounts then due upon which to base a penalty. See Nicolasa Martinez, 43 Van Natta 1638 (1991), aff'd Martinez v. Dallas Nursing Home, 114 Or App 453 (1992). Here, as we have noted, the employer did not timely accept or deny claimant's aggravation claim. By failing to timely respond to the claim, the employer delayed the ultimate resolution of the dispute and placed a greater burden on claimant to learn of his rights and to prove his claim. See Charles E. Condon, 44 Van Natta 726, 727 (1992). Its unexplained nonaction had the effect of delaying benefits under the compensable claim. Therefore, the employer unreasonably resisted the payment of compensation to claimant and an attorney fee pursuant to ORS 656.382(1) is assessed on this basis. See Richard J. Stevenson, 43 Van Natta 1883, 1884 (1991).

Having considered the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable carrier-paid fee for claimant's counsel's services concerning the employer's untimely claims processing is $500. In reaching this conclusion, we have particularly considered the time devoted to the issue, as reflected by the record, and the value to claimant of the interest involved.

Attorney Fees

The Referee awarded claimant an assessed attorney fee, because his counsel's involvement resulted in obtaining acceptance of the "de facto"-denied aggravation claim without a hearing. We agree and adopt the Referee's conclusion and reasoning with the following supplementation.

We find that claimant's counsel was instrumental in obtaining compensation for claimant under the aggravation claim without a hearing. See Deborah K. Atchley, 44 Van Natta 1435 (1992). In reaching this conclusion, we note the following evidence of counsel's services. The attorney accompanied claimant to discuss the claim with Dr. McKillop on June 17, 1991, (see Ex. 1), which resulted in McKillop's filing of the aggravation claim on claimant's behalf (see Ex. 2). On July 31, through his legal assistant, claimant's attorney formally notified the employer that he represented claimant, requested discovery, noted that a claim had been filed, and requested that the claim be processed. (Ex. 4). On September 17, 1991, through his legal assistant, claimant's attorney requested a copy of an IME's report. (Ex. 9). On September 23, 1991 claimant's attorney requested a hearing from employer's de facto denial of the aggravation claim. Considering this evidence, we find that that claimant is entitled to an assessed attorney fee under ORS 656.386(1), for his counsel's services prior to hearing concerning the "de facto" denial. See Deborah K. Atchley, supra.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that the Referee's award of a $1,250 assessed attorney fee for services rendered prior to the hearing is appropriate. In reaching this conclusion, we have particularly considered the time devoted to the issue, as reflected by the record, and the value to claimant of the interest involved.

ORDER

The Referee's order dated December 10, 1991 is reversed in part and affirmed in part. For the insurer's failure to process claimant's aggravation claim, claimant's counsel is awarded an assessed attorney fee of $500, payable by the insurer. For claimant's counsel's services rendered prior to hearing in prompting the rescission of the insurer's "de facto" denial, claimant's attorney is awarded $1,250, to be paid by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
RANDAL L. BROWN, Claimant
WCB Case No. 91-04556
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Michael V. Johnson's order which affirmed a Notice of Closure awarding 15 percent (48 degrees) unscheduled permanent disability for the low back. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

Claimant became medically stationary on February 15, 1990. (Ex. 12).

At the time of his injury in 1987, claimant worked as a truck driver. His duties entailed lifting and carrying 50-pound bags and boxes of explosives, moving rock crusher screens weighing 100-plus pounds, and moving truck equipment weighing in excess of 100 pounds. (Tr. 7-9).

In the 10 years preceding the date of hearing, claimant's highest SVP was 4, achieved by successfully performing his job as a truck driver for over 6 months.

CONCLUSIONS OF LAW AND OPINION

In evaluating the extent of claimant's permanent disability, the Referee applied the disability standards in effect at the time of the corrected Notice of Closure on April 18, 1991. WCD Admin. Order 2-1991 (effective April 1, 1991). The Referee did so based on the parties' stipulation. (Tr. 3).

However, because claimant became medically stationary before July 1, 1990, the disability standards which became effective January 1, 1989 (WCD Admin. Order 6-1988) must be applied in rating his disability. OAR 436-35-003(1). The Referee and the Board are also required to apply these standards. OAR 438-10-010. Accordingly, we apply former OAR 436-35-270 through 436-35-440 to the rating of claimant's unscheduled permanent disability. WCD Admin. Order 6-1988.

We note that on review claimant contests portions of a version of the standards that are not applicable. Therefore, we do not address the parties' arguments regarding the validity of those standards.

Because claimant became medically stationary before July 1, 1990, we rate disability as of the date of hearing, not as of the date of reconsideration. The amendments to ORS 656.268(4), 656.283(7) and 656.295(5) do not apply. See Or Laws 1990, ch 2, § 54(3); Stephen A. Roberts, 43 Van Natta 1815 (1991).

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, skills and training. Former OAR 436-35-300(6). Once determined, the values for age and education are added. The sum is then multiplied by the appropriate adaptability value. The product of those values is added to the impairment value, and any fractional number is rounded to the next whole number. This yields the percentage of unscheduled permanent partial disability. Former OAR 436-35-280.

Age

The appropriate value for claimant's age of 43 years is 1. Former OAR 436-35-290.

Formal Education

Claimant is a high school graduate. Therefore, the appropriate value for formal education is 0. Former OAR 436-35-300(3)(a).

Skills

The highest specific vocational preparation time (SVP) demonstrated by a worker during the ten years preceding the date on which disability is determined is used to establish the value for skills. Former OAR 436-35-300(4). Here, disability is determined at the time of the hearing. See, e.g., Edward L. Sullivan, 43 Van Natta 932 (1991). The position which claimant successfully performed during the ten years preceding the date of the hearing, which has the highest SVP, is log truck driver, DOT # 904.683-010. (Ex. 6-2). Therefore, the appropriate value for skills is 3. Former OAR 436-35-300(4).

Training

Whether a worker is entitled to a value for training under former OAR 436-35-300(5) is dependent upon whether the worker has demonstrated competence in some specific vocational pursuit. Competence in some "specific vocational pursuit" under former OAR 436-35-300(5) means the acquisition of training on or off the job to perform other than an entry level position. Larry L. McDougal, 42 Van Natta 1544 (1990).

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

Claimant's total educational value is 3, the sum of the values for formal education, skills and training. Former 436-35-300(6).

Adaptability

The adaptability value for a worker who has either returned to modified work or received a work offer is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the physical capacity of the worker's usual and customary work with the physical capacity required by the modified work. This is true even though the worker may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the former "standards" generally. Those definitions contained in former OAR 436-35-310(4)(a)-(d) are utilized to categorize physical capacities. Kenneth Kjelland, 42 Van Natta 1000 (1990).

In this case, claimant's usual and customary work required the physical capacity to do heavy work. Claimant's modified work as a forestry aide, performed subject to claimant's physical limitations, required a light physical capacity. See generally, Thomas W. Lundy, 43 Van Natta 2307 (1991); Terry W. Prater, 43 Van Natta 1288 (1991). Therefore, the appropriate adaptability value is 2.5. Former OAR 436-35-310(3).

Impairment

Claimant had a laminotomy and discectomy at L4-5, Steffe plating at L4-5, and intertransverse fusion at L4-5. (Exs. 4C, 4E). Therefore, he is entitled to 5 percent impairment for the surgery, as well as 3 percent impairment for spinal fusion of 2 lumbar levels. Former OAR 436-35-350(2), (3).

With regard to spinal ranges of motion, claimant retains 80 degrees of thoracolumbar flexion, which entitles him to 1 percent impairment. See Ex. 10; former OAR 436-35-360(6). He also retains 25 degrees of thoracolumbar extension, which entitles him to .5 percent impairment. Former OAR 436-35-360(7); Ex. 10. Range of motion values are added for a total impairment value of 1.5 percent for loss of spinal range of motion. Former OAR 436-35-360(10).

Multiple residuals in one body area are combined to obtain the final impairment rating for that area. Former OAR 436-35-360(11). Combining 5 percent and 3 percent and 1.5 percent results in a final impairment rating of 9.5 percent.

The Computation of Disability

Having determined each of the values necessary under the "standards", claimant's unscheduled permanent disability may be calculated. The sum of the value for claimant's age (1) and the value for claimant's education (3) is 4. The product of that value and the value for claimant's adaptability (2.5) is 10. The sum of that product and the value (9.5 percent) for claimant's impairment is 19.5 percent. That value (after rounding) represents claimant's unscheduled disability. Former OAR 436-35-280. Therefore, claimant's permanent unscheduled disability under the "standards" is 20 percent.

ORDER

The Referee's order dated August 12, 1991 is modified. In addition to the Notice of Closure award, claimant is awarded 5 percent (16 degrees) unscheduled permanent disability, giving him a total award to date of 20 percent (64 degrees) unscheduled permanent disability for his low back injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, payable directly to claimant's attorney by the SAIF Corporation, not to exceed $3,800.

In the Matter of the Compensation of
TERESA L. ERP, Claimant
WCB Case No. 91-10022
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Brazeau and Moller.

Claimant requests review of Referee Neal's order that affirmed an Order on Reconsideration awarding no unscheduled permanent disability. In her brief, claimant objects to the Referee's exclusion of two medical reports generated after issuance of the Order on Reconsideration. On review, the issues are evidence and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Evidence

Claimant contends that the Referee erred in admitting Exhibits 24 and 25 only for purposes of appeal. We conclude that the Referee properly exercised her discretion by refusing to consider the exhibits for purposes of her decision.

The extent of claimant's unscheduled disability is to be rated as of the date of the Order on Reconsideration. ORS 656.283(7). Here, the Order on Reconsideration issued on July 16, 1991. Exhibits 24 and 25, which are reports of claimant's attending physician, pertain to claimant's disability two and three months after the Order on Reconsideration. The exhibits, therefore, could not be relevant to a rating of claimant's disability as of the time of the Order on Reconsideration. Consequently, we conclude that the Referee's refusal to consider them for purposes of her substantive decision was correct.

Claimant further argues that because the Department did not appoint a medical arbiter pursuant to ORS 656.268 and 656.283, the record has been insufficiently developed. She, therefore, asserts that our consideration of Exhibits 24 and 25 is necessary in order to complete the record. We disagree.

Although a claimant's request for reconsideration can be sufficient to initiate the reconsideration process, the Director is not required to appoint an arbiter prior to issuing an order on reconsideration, unless the request for reconsideration specifically disagrees with the impairment findings of the

attending physician. Former OAR 436-30-050(4)(d); Doris C. Carter, 44 Van Natta 769 (1992); also see Charles R. Butler, 44 Van Natta 994 (1992).

Here, claimant's request for reconsideration did not disagree with the impairment findings of her attending physician, Dr. Baum. Neither did the request disagree with the impairment findings of claimant's previous physician, Dr. McCluskey, or the consulting physician, Dr. Takacs. We, therefore, conclude that the Director was not required to appoint a medical arbiter under the provisions of ORS 656.268 and 656.283. Moreover, we find that the record has been sufficently developed. Accordingly, like the Referee, we decline to consider Exhibits 24 and 25 in determining the extent of claimant's unscheduled permanent disability.

Extent of unscheduled permanent disability

We adopt the Referee's order with regard to the issue of extent of unscheduled permanent disability.

ORDER

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

August 24, 1992 Cite as 44 Van Natta 1729 (1992)

In the Matter of the Compensation of
SHARON E. SMITH, Claimant
WCB Case No. 91-13180
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Quillinan's order that dismissed her request for hearing for lack of jurisdiction. On review, the issues are jurisdiction and, if the Hearings Division has jurisdiction, medical services and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

The SAIF Corporation does not dispute the Director's order, which authorized the requested chiropractic treatments.

CONCLUSIONS OF LAW AND OPINION

The Referee found that she lacked jurisdiction over claimant's claim for palliative medical services, because the Director's order authorizing the requested chiropractic treatment became final without being appealed. We reach the same result, based on the following reasoning.

We recently held that the Director has exclusive jurisdiction over palliative care issues that would otherwise not be compensable under one of the exceptions listed in ORS 656.245(1)(b). Rexi L. Nicholson, 44 Van Natta 1546 (1992). Here, claimant does not come within any of the exceptions that qualify palliative care as compensable. ORS 656.245(1)(b). The review process of a Director's order regarding these otherwise noncompensable palliative care issues includes an administrative review by right and a discretionary contested case hearing before the Director. Rexi L. Nicholson, supra. The statutory scheme does not include review of a Director's order regarding an otherwise noncompensable palliative care issue by the Board or its Hearings Division. Id.[1]

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[1] Although a signatory to this order, Board Member Gunn directs the parties attention to his dissent in Rexi L. Nicholson, supra.

In addition, we adopt those portions of the Referee's order, on page 2, which address claimant's argument that SAIF's April 24, 1991 and July 19, 1991 letters to Dr. Danner (Exs. 33 & 36) amount to a denial of claimant's current condition. In this regard, we also note that the letters specifically refer to claimant's need for "palliative care." Considering the nature of the claim, a request for authorization for chiropractic treatments, and the letters' limiting language, we agree with the Referee's conclusion that there was no issue concerning compensability before her. See Charles E. Condon, 44 Van Natta 726 (1992), citing Gene C. Dalton, 43 Van Natta 1191 (1991).

Finally, we acknowledge claimant's request for penalties and attorney fees based on SAIF's allegedly unreasonable "de facto" denial. However, as we have stated, there is no compensability issue in this case. Claimant was not a party to her doctor's request for authorization of palliative medical services. Therefore, when those services were authorized, claimant did not prevail on a rejected case, as required by ORS 656.386(1). Moreover, we find no evidence of unreasonable resistance to the payment of compensation or unreasonable delay in paying compensation or processing this claim. Under these circumstances, claimant has not established entitlement to a penalty or attorney fee in this case.

ORDER

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

In the Matter of the Compensation of
SUSIE A. FIMBRES, Claimant
WCB Case No. 90-16803
ORDER ON RECONSIDERATION
Black, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

On June 9, 1992, we filed with the Court of Appeals a Notice of Withdrawal of our October 8, 1991 Order on Review. See ORS 183.482(6); ORAP 4.35. We took such an action to reconsider our holding concerning the applicability of amended ORS 656.262(6) to the insurer's stipulated acceptance of claimant's cervical spondylosis claim. The primary question is whether the acceptance of the claim by stipulation operated to preclude the insurer from later issuing a "back-up" denial of the accepted condition based on clear and convincing evidence that the condition is not compensable.

FINDINGS OF FACT

In May 1987, claimant filed an 801 Form asserting a claim for a stiff neck and left arm pain as the result of an industrial accident occurring on May 1, 1987. (Ex. 3). In July 1987, the insurer accepted this claim as a nondisabling injury by marking "accepted" on the 801 form. Claimant's injury was initially diagnosed as a cervical/dorsal sprain/strain. Claimant continued to experience neck and left arm symptoms. In February 1989, claimant was seen by Dr. Corson for her continuing symptoms. At that time, Dr. Corson opined that claimant had cervical spondylosis which caused her ongoing symptoms.

On March 7, 1989, the insurer denied claimant's current cervical spondylosis condition on the grounds that it was unrelated to her compensable injury. The insurer issued the denial in response to medical reports submitted by Dr. Corson indicating that claimant was being treated for cervical spondylosis. Claimant requested a hearing on the March 7, 1989 denial.

Between March 1989 and July 1990, the attorneys for the respective parties corresponded with Dr. Corson concerning whether there was any causal relationship between claimant's cervical spondylosis condition and her 1987 sprain/strain injury. In a letter to the insurer dated April 4, 1989, Dr. Corson stated that he was unable to relate claimant's current symptoms to the 1987 compensable injury. (Ex. 14). On June 8, 1989, however, he "checked the box" on a letter from claimant's counsel indicating that claimant's "current problems are related to her injury of May 1, 1987." (Ex. 15). By a July 26, 1989 letter to the insurer's attorney, he opined that "the degree of that spondylosis does not appear to be any greater than that which is typical for women in [claimant's] age group, with the result

that it is not possible to say, within any degree of medical probability, that the accepted strain of May 1, 1987 either caused or accelerated the degenerative condition." (Ex. 16-1). On September 15, 1989 he opined that the 1987 sprain injury caused claimant's preexisting spondylosis condition to become symptomatic. (Ex. 25).

On March 7, 1990, the insurer amended its March 7, 1989 denial so as to deny only responsibility for claimant's current spondylosis condition. As amended, the denial indicated that claimant's subsequent employment with another carrier independently contributed to a worsening of claimant's cervical condition. (Ex. 40).

On June 20, 1990, the parties entered into a stipulation whereby the insurer rescinded its March 7, 1990 denial and agreed to "reopen the claimant's May 1, 1987 nondisabling claim."

In July 1990, Dr. Corson reported that a myelogram and CT scan indicated that claimant's cervical condition had continued to worsen. At that time, Dr. Corson recommended cervical surgery. In August 1990, claimant was examined by the Medical Consultants Northwest. The Consultants opined that claimant's worsened cervical condition was due to a natural progression of her cervical spondylosis and not due to the compensable injury.

On August 16, 1990, the insurer issued a denial of claimant's worsened cervical condition for the reason that claimant's "current condition diagnosed as cervical spondylosis is unrelated to [claimant's] industrial injury of May 1, 1987." On August 17, 1990, claimant's treating physicians, Dr. Corson and Dr. Purtzer, concurred with the opinion of the Medical Consultants Northwest that claimant's cervical spondylosis condition was unrelated to claimant's May 1, 1987 compensable injury. (Exs. 51, 52).

On November 9, 1990, the insurer rescinded its August 16, 1990 denial and issued a new denial which stated in part:

> "We have recently received information that you are seeking treatment and surgery for a degenerative neck condition, diagnosed as cervical spondylosis which you allege to be related to your injury of May 1, 1987. Medical evidence in your file indicates that your current degenerative condition, diagnosed as cervical spondylosis is unrelated to your industrial injury of May 1, 1987 and, therefore, without waiving further questions of compensability, we submit this partial denial of your claim for benefits."

FINDINGS OF ULTIMATE FACT

The insurer accepted claimant's cervical spondylosis condition in good faith by the stipulation entered into on June 20, 1990.

After its good faith acceptance of the spondylosis condition, the insurer obtained clear and convincing medical evidence that claimant's cervical spondylosis condition was not compensably related to claimant's May 1, 1987 industrial injury.

On November 16, 1990, the insurer issued a "back-up" denial of claimant's cervical spondylosis condition.

CONCLUSIONS OF LAW AND OPINION

In our original Order on Review, we agreed with the Referee's conclusion that the insurer's November 9, 1990 denial of the cervical spondylosis condition was an improper "back-up" denial. Susie A. Fimbres, 43 Van Natta 2289 (1991). We reasoned that because the insurer accepted claimant's cervical spondylosis claim by entering into the June 20, 1990 stipulation, the insurer was precluded by the principles of res judicata from later revoking its acceptance based on subsequently obtained evidence that the condition was not compensable. Like the Referee, we did not discuss amended ORS 656.262, and accordingly reached a decision which, after our reconsideration of the matter, we conclude was erroneous.

Claimant requested a hearing in this matter after May 1, 1990, and a hearing was convened after July 1, 1990. Therefore, the 1990 amendments to the Workers' Compensation Law apply to this case. Or Laws 1990 (Special Session), Ch 2, section 54; See Ida M. Walker, 43 Van Natta 1402 (1991).

As relevant, amended ORS 656.262(6) provides in relevant part:

> "Written notice of acceptance or denial shall be furnished to the claimant * * * within 90 days after the employer has notice or knowledge of the claim. However, if the insurer or self-insured employer accepts a claim in good faith but later obtains evidence that the claim is not compensable * * * 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."

Subsequent to our original Order on Review in this case, we issued our order in Sharon J. True, 44 Van Natta 261 (1992). There, SAIF had denied compensability of the claimant's hepatitis condition. One day before hearing, SAIF rescinded its denial and then formally accepted the claim on the day of hearing. Approximately four months later, SAIF issued a "back-up" denial based on evidence that the claimant had not been exposed to hepatitis during employment with SAIF's insured. The Referee set aside SAIF's "back-up" denial based on her conclusion that SAIF was precluded by res judicata from issuing a "back-up" denial. On review, we disagreed. We held that because SAIF accepted the claim in "good faith" and issued a back-up denial within two years from that acceptance, its denial was procedurally proper under amended ORS 656.262(6). We said:

> "We conclude that amended ORS 656.262(6) operates to permit SAIF to issue its 'back-up' denial. * * * Although not expressly dealing with res judicata situations, ORS 656.262(6) expresses a clear legislative intent to allow 'back-up' denials where a claim has previously been accepted, subject only to those limitations expressly set forth in the statute. We hold that the statute controls our resolution of this case." (Id. at 263)

In reaching this conclusion in Sharon J. True, we observed that the focus of amended ORS 656.262(6) is on an acceptance in "good faith," not on whether the acceptance was furnished to the worker within 90 days of the employer's notice of the claim. Our review of legislative history revealed that it "was the hope of the legislature that carriers would be more willing to accept uncertain claims if they could subsequently 'back-up' and deny the claim based on clear and convincing evidence that the claim was not compensable." (Id. at 264). We therefore held that SAIF's rescission of its denial and acceptance of the claim one day before the hearing was in "good faith", because when it denied the claim, its liability was uncertain, and although the acceptance came one day before the hearing, it was given promptly after SAIF received a report from claimant's treating physician supporting compensability of the claim. Accordingly, the case was remanded to the Referee for a hearing to determine whether SAIF established by clear and convincing evidence that the claim is not compensable.

We find that our reasoning in Sharon J. True applies equally here. ORS 656.262(6) controls our resolution of this case, because it expresses a clear legislative intent to allow "back-up" denials, subject only to the following four limitations: (1) the insurer accepts the claim in "good faith"; (2) the insurer subsequently obtains evidence that the claim is not compensable; (3) a "back-up" denial is issued within two years from the acceptance; and (4) if the denial is contested at hearing, the insurer proves by clear and convincing evidence that the claim is not compensable.

Here, the last three statutory limitations have clearly been met. After accepting the cervical spondylosis claim on June 20, 1990 as part of the original 1987 compensable injury claim, the insurer received additional medical evidence that the spondylosis condition was not compensable. On the basis of the additional evidence, the insurer issued a "back-up" denial on November 19, 1990, well within two years from the acceptance. Furthermore, through the additional medical evidence, SAIF established by clear and convincing evidence that the spondylosis condition was not compensable. Specifically, the Medical Consultants Northwest opined and claimant's treating physicians, Corson and Purtzer, agreed that claimant's current spondylosis condition is unrelated to claimant's May 1, 1987 compensable sprain injury. The record contains no medical evidence to the contrary.

We also conclude that the record clearly establishes that the June 20, 1990 stipulated acceptance was in "good faith". This case began as a nondisabling injury claim which the insurer accepted as such in July 1987. The present dispute actually arose in February 1989 when Dr. Corson attributed claimant's symptoms to a cervical spondylosis condition without relating that condition to the compensable injury. Absent evidence of a causal relationship, the insurer denied the condition on March 7, 1989. Between March 1989 and June 1990, the insurer's liability for the spondylosis condition can only be described as uncertain according to the available medical evidence. Indeed, given Dr. Corson's repeated changes of opinion on the question of causation, the insurer had a legitimate doubt as to its liability for the spondylosis condition. First, in April 1989, Dr. Corson could not relate claimant's symptoms to the compensable injury. On June 8, 1989, he stated, without explanation, that claimant's problems were causally related to the compensable injury. One month later, he concurred with the insurer's attorney's statement that the compensable injury did not cause or worsen claimant's preexisting cervical spondylosis condition. In September 1989, he opined that the 1987 sprain injury caused the spondylosis condition to become symptomatic. Despite the foregoing, on the basis of Dr. Corson's September 1989 report, the insurer amended its denial so as to deny responsibility only and on June 20, 1990, accepted the spondylosis condition. Under such circumstances, we conclude that the insurer's acceptance was "in good faith".

Accordingly, the insurer's denial must be reinstated and upheld.[1]

ORDER

The Referee's order dated January 16, 1991 is reversed. The insurer's denial is reinstated and upheld. The Referee's award of $1,200 assessed attorney fee is also reversed.

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[1] We wish to emphasize that we do not imply by our decision here that it is impossible or even difficult for two parties to structure an agreement in a way that precludes a back-up denial. For instance, a stipulation by which the insurer accepts the claim and expressly promises not to issue a back-up denial irrespective of evidence which might later be obtained would be enforced by the Board strictly in accordance with its terms. Here, however, the insurer agreed in the stipulation only to accept the claim. The stipulation does not deal with the subject of back-up denials or purport to resolve a dispute over that subject, as the parties had no dispute or agreement concerning that subject. Accordingly, as written, the stipulation did not preclude issuance of a back-up denial under ORS 656.262.

Likewise, the present case does not involve an order issued after a hearing, setting aside an insurer's denial, and by the force of which the insurer is compelled over its objection to "accept" the claim. Recognizing that every case must be decided on its particular merits, it is difficult for us to imagine how an insurer's claims processing pursuant to such an order could ever constitute an "acceptance in good faith" within the meaning of ORS 656.262. In any event, that question, is not now before us.

Board Member Kinsley specially concurring.

I concur with the majority's opinion with the exception of the second paragraph of the footnote. I decline to express my opinion on a set of facts not before us; that is, the applicability of ORS 656.262(6) where a claim has been ordered accepted. I will not preclude the possibility of a persuasive cogent argument in a future case which would persuade me to decide other than the policy expressed in the second paragraph of the footnote.

Board Members Gunn and Hooton dissenting.

We agree with the majority that we failed to consider the applicability of amended ORS 656.262(6) in the instant case. However, upon reconsideration we disagree with the majority's analysis. The primary issue is not whether the insurer can issue a "back-up" denial, but rather, whether it is proper for the Board to set aside the stipulated order. Granted, resolution of the latter will decide the former, but it is with the latter where the threshold issue lies. Therefore, we must disagree with the majority's conclusion that a stipulation may constitute a "good faith" acceptance under ORS 656.262(6).

In reaching its decision, the majority relies on our previous opinion in Sharon J. True, 44 Van Natta 261 (1992). We would refer the parties to the dissent in that case. Moreover, the present case is distinguishable from True.

Here, a stipulated settlement was reached prior to hearing and approved by a referee. In their June 18, 1990 stipulation, the parties specified that the insurer would rescind its March 7, 1990 denial and process claimant's claim. In accordance with their stipulation, claimant's hearing request from the denial was dismissed.

On the other hand, in True, the carrier did not "accept" the claim in accordance with a stipulation. Rather, the carrier accepted the claim "on the courthouse steps" by rescinding its denial and accepting the claim prior to hearing. The carrier's acceptance was not encased in either a stipulation or Referee's order. The parties did not negotiate for, nor enter into, a signed agreement requiring referee approval. Instead, the sole issue resolved by order (stipulated or otherwise) was claimant's entitlement to a carrier-paid attorney fee. Thus, the True acceptance was not the result of an agreement in which each party released rights and incurred obligations.

Therefore, the majority's reliance on True does not support their finding that the present stipulation could equal a good faith acceptance. Moreover, we suggest that the reference to acceptance in good faith in ORS 656.262(6) envisions a claim processing decision unencumbered by a litigation order. To reach any other conclusion results in an unwarranted expansion of the plain language of the statute, legislative history and the purpose behind the language. Expanding the definition of a "good faith" acceptance to encompass the terms of a stipulation is contrary to the purpose and policy of Worker's Compensation Law. In particular, such law declares:

> "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) (Emphasis supplied).

If a stipulation can be set aside under the provisions of ORS 656.262(6), without establishing unconscionableness or the necessity for such an extraordinary remedy, then insurers will have an incentive to expand litigation to those matters in which parties have sought to resolve disputes by a settlement agreement. For all practical purposes, settlements would be decimated as ineffectual, as would agreements be rendered without meaning.

Further, regardless of the grounds upon which a stipulated order might be set aside, as a policy, we have regarded vacating such settlements to be an extraordinary remedy, granted sparingly, and only in the most extreme and unconscionable situations. We see no reason to break from our longstanding and equitable policy now. See Schulz v. State Compensation Department, 252 Or 211 (1968) (stipulations may be set aside, however, a standard for when they must be set aside has not been established and the agreement at hand was properly set aside where to bind claimant to it would violate the spirit or public policy of workmen's compensation statutes); Gerardo C. Aguilar, 44 Van Natta 478 (1992) (stipulation not set aside upon pro se claimant's request to not be bound by agreement entered into by counsel in his absence in which claimant claims dissatisfaction with counsel's efforts); MaryLou Claypool, 34 Van Natta 943, 946 (1983) (request for setting aside stipulation is considered extraordinary remedy and not granted where employer did not establish mutual mistake or material breach); James Leppe, 31 Van Natta 130 (1981) (stipulation not set aside even in light of facts that the referee erred in approving the settlement due to "the illegality of the overreaching attorney fee").

In MaryLou Claypool, supra, the Board held that settlement agreements can be viewed in two ways. Either they are "private contractual agreements subject to a condition subsequent, i.e., ratification by a third party -- a Referee or the Board" or they can be viewed as an "agency order." Id at 946.

Here, as a contract, the stipulation represents the insurer agreement to reopen the claim with the understanding that claimant's hearing request would be dismissed with prejudice to all issues raised or raiseable between the parties. By the plain terms of the agreement no "good faith" acceptance occurred. Rather, what occurred was an "accommodation of diverse interests." The reopening of the claim was conditioned upon a waiver by claimant of certain rights and privileges. In contrast, an accepted claim is the unconditional acceptance by the carrier of responsibility for a compensable injury or disease. As is apparent from the stipulation, the parties weighed their choices and, based upon skilled judgment, chose to enter into a contractual arrangement; i.e., the hearing request would be

dismissed in return for the insurer's agreement to process the claim. The parties, each of whom was represented by legal counsel, obviously signed this agreement with the intent to be bound by its terms.

Accordingly, as a contractual agreement, the stipulation can now only be attacked through the standard contract defenses available, i.e., misrepresentation, duress, mistake, etc. Here, none of these defenses were raised or argued. Moreover, the record does not support a finding that any of these grounds are present.

Additionally, as an agency order, the grounds for setting aside a stipulation are substantially the same as the standard contract defenses. See MaryLou Claypool, supra at 946. These include mistake, inadvertence, surprise, excusable neglect, fraud, misrepresentation or other conduct of an adverse party. See Rule 71B of the Oregon Rules of Civil Procedure. Again, none of these defenses were raised or argued and the record does not support a finding that any of these grounds are present.

Under either analysis, "good faith" acceptance is not one of the grounds for setting aside a stipulated agreement. Therefore, inasmuch as a stipulation does not constitute an "acceptance" of any faith be it "good" or "bad", such a requirement fails the requirement of a "good faith acceptance" and does not come under the provisions of ORS 656.262(6).

The approach we are advocating furthers a policy of encouraging finality to the process of claim adjudication. This concept is consistent with the rationale articulated by the court in Knapp v. Weyerhaeuser Co., 93 Or App 670 (1988). In Knapp, the employer issued a "back-up denial" of the claimant's occupational disease claim for a back condition after a Referee had set aside the employer's prior denial of the claim. The employer based its "back-up denial" on information obtained subsequent to the prior litigation. When the claimant's hearing request from the "back-up denial" was filed more than 60 days after the denial, the employer moved for dismissal of the hearing request. The Board affirmed the Referee's dismissal order.

The Knapp court reversed the Board's order, concluding that there were no circumstances that permitted the employer's denial. Reasoning that there must be some finality to the process of claims adjudication, the court determined that such a goal would not be furthered by a policy permitting readjudication each time that a party discovers a nondisclosure or misrepresentation by the other party.

In reaching its conclusion, the court held that Bauman v. SAIF, 295 Or 788 (1983) (which permits a "back-up denial" based on fraud, misrepresentation, or other illegal activity) was inapplicable because the Bauman rationale permits an employer to deny a claim that it has accepted if the acceptance was made under circumstances of fraud or misrepresentation. (Emphasis in original). Reasoning that the Bauman holding did not permit a collateral challenge to a final Board order on the same grounds, the court concluded that when the employer had once denied the claim and had the opportunity to litigate the denial on its merits, it could not do so again.

Subsequent to the Knapp holding, the legislature has amended ORS 656.262(6) to permit a carrier to revoke its claim acceptance up to 2 years from the date of its acceptance if the carrier "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." If claimant contests such a denial at a hearing, the carrier must prove that the claim is not compensable by clear and convincing evidence. ORS 656.262(6).

Notwithstanding the recent amendments to ORS 656.262(6), we have held that the Bauman principles remain in place. Anthony G. Ford, 44 Van Natta 240 (1992). Since the Bauman rationale continues, it naturally follows that the Knapp reasoning would likewise remain. In other words, consistent with the Knapp holding, a "back-up denial" based on the Bauman grounds would be invalid when a carrier had once denied the claim and had an opportunity to litigate that denial.

Here, in accordance with Knapp, had the insurer based its denial on fraud, misrepresentation or other illegal activity, such a denial would be impermissable because the insurer had the opportunity to litigate its prior denial. Nevertheless, relying on the "good faith" acceptance provision in ORS 656.262(6), the majority reasons that the insurer may contest the compensability of the previously accepted underlying claim despite the insurer's prior decision to forego an opportunity to litigate its initial denial of the claim. Inasmuch as that prior decision was encompassed within a stipulated order

which dismissed claimant's hearing request pertaining to that initial denial, we respectfully submit that such circumstances do not constitute a "good faith" acceptance.

Indeed, a stipulation by its very nature is a document to settle, once and for all, disputed facts, in lieu of litigation. By its terms and process, it is not an acceptance. By its express terms, a stipulation can, and often does limit claimant's right to litigate matters such as interim compensation not necessarily related to the compensability of the claim. ORS 656.262(6) does not return to claimant the rights foreclosed. An "acceptance" on the other hand is an independent and voluntary choice by the insurer for which no consideration is provided or rights foreclosed. By rather simple logic, it is apparent that if a claim is being accepted, the shortest distance to accomplishing that result is the straight course of simply accepting it. Any other route, such as entering into a stipulation, can only leads us to reject the premise that a "good faith" acceptance has been accomplished by means other than accepting a claim.

Emphatically, to do otherwise, would foster a policy which permits readjudication of the merits of the claim, thereby causing profound damage to the concept espoused in Knapp of finality in the process of claims adjudication.

In conclusion, the danger and folly of expanding the Board's permissive power to set aside stipulations was aptly addressed previously in James Leppe, supra at 131. A dozen years ago, it was stated that:

> "This Board concludes that the authority to set aside stipulations should be used very sparingly, only in the most unconscionable of situations. Our Referees are now approving about 7,000 stipulated settlements per year. This Board expects these approvals to be taken as seriously as the about 3,000 cases per year decided by the Referees after hearing. A more expansive view of our Schulz authority would not encourage serious Referee attention to the approval of stipulated settlements. Also, a more expansive view of our Schulz authority could jeopardize the quantity and quality of settlements by creating a large question mark about the finality of all settlements."

Presently, in 1992, the quantity and seriousness of the cases before us has not diminished, and therefore, neither should our encouragement of setting aside settlements expand. Accordingly, we must dissent.

August 31, 1992 Cite as 44 Van Natta 1736 (1992)

In the Matter of the Compensation of
HAROLD G. HESS, JR., Claimant
WCB Case Nos. 90-22533, 90-12097
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Williams, et al., Defense Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Louisiana-Pacific, a self-insured employer, requests review of those portions of Referee Leahy's order that: (1) set aside its denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome condition; and (2) upheld the SAIF Corporation's denial, on behalf of Island City Saw, of the same condition. Claimant cross-requests review of that portion of the order that awarded an assessed fee of $2,200. On review, the issues are compensability, responsibility, 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

Compensability

In order to prove a claim for occupational disease, the "worker must prove that employment conditions were the major contributing cause of the disease or its worsening." ORS 656.802(2). Existence of a disease or worsening "must be established by medical evidence supported by objective findings." Id.

Louisiana-Pacific asserts that claimant failed to prove that his bilateral carpal tunnel syndrome is compensable as an occupational disease. We agree with the Referee that claimant carried his burden of proof in this regard. Dr. Eisler, neurologist, who saw claimant on referral from his treating physician, reported that claimant's "carpal tunnel syndromes are related to his industrial activity." (Ex. 45). In a subsequent deposition, Dr. Eisler stated that claimant had a "double cause for his carpal tunnel syndrome," including work activities and a congenital predisposition. (Ex. 48-21). Dr. Eisler found that work activities were the "primary" or "major reason" for claimant's condition. (Id. at 22-23).

Dr. Eisler's opinion is contradicted only by the opinion of claimant's treating physician, Dr. Carpenter, orthopedic surgeon. In a letter drafted by the employer's attorney, Dr. Carpenter concurred in the statement that claimant's "osteoarthritic type conditions, degenerative arthritis * * * coupled with normal wear and tear of his wrists have combined to cause the development of the carpal tunnel symptoms and condition." (Ex. 44-1). Dr. Carpenter could not conclude that claimant's work "was the major contributing cause of the development of the carpal tunnel symptoms or condition." (Id).

In a subsequent letter, however, Dr. Carpenter stated that he would "yield to the referee to do the accounting of [claimant's] activities over the last several years." (Ex. 46). Dr. Carpenter also stated that "it is [claimant's] belief, and he has conveyed this belief, that the predominance was saw filing [in causing his carpal tunnel syndrome] and, if the referee sees it this way, I am sure that [claimant] will prevail." (Id).

Because Dr. Carpenter essentially refused to provide an opinion regarding causation of claimant's condition, instead deferring to the Referee for such a conclusion, we find that, although he is the treating physician, his opinion is entitled to little weight. See Weiland v. SAIF, 64 Or App 801, 814 (1983). Therefore, relying on the opinion of Dr. Eisler, to whom claimant was referred by Dr. Carpenter, we conclude that claimant proved that work activities were the major contributing cause of his carpal tunnel syndrome and, therefore, he established compensability under ORS 656.802.

Louisiana-Pacific asserts that claimant participated in other activities that could have contributed to his condition, including riding a motorcycle to and from work, and repairing small engines, which Louisiana-Pacific contends was established by the appearance of grime on claimant's hands at the time of Dr. Eisler's examination. We find that Dr. Eisler's notation concerning grime is not sufficient to prove that claimant was participating in hand-intensive activity in June 1990. Moreover, there is no evidence that claimant rode his motorcycle more than a couple times while working for Louisiana-Pacific. Thus, we find no proof to substantiate Louisiana-Pacific's contention concerning other activities that could have contributed to claimant's condition.

Responsibility

Next, Louisiana-Pacific contests the Referee's conclusion that it is responsible for claimant's condition. The Referee based this conclusion on his finding that Louisiana-Pacific was responsible under both ORS 656.308(1) and the last injurious exposure rule.

We first note that ORS 656.308(1) is not applicable where there is no prior accepted condition and a determination must be made concerning the assignment of initial liability for a compensable condition between successive employers. See Fred A. Nutter, 44 Van Natta 854 (1992). Rather, in such cases, the last injurious exposure rule may be invoked to allocate responsibility. See id. Here, although claimant sustained a compensable shoulder injury in 1988, the prior claim did not include his carpal tunnel syndrome. Therefore, because initial liability of the carpal tunnel syndrome condition is at issue, we do not determine responsibility under ORS 656.308(1). Moreover, because claimant has invoked the last injurious exposure rule, we analyze the responsibility issue under that rule of law.

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, 293 Or 239, 248 (1982). If the claimant is not in potentially causal employment when disability occurs, the last such employer is assigned initial liability. 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, claimant reported to his physicians, and testified at hearing, that he first experienced arm numbness in 1988 while working for Island City Saw as a saw filer. After working for short periods of time at other shops, claimant began work at Louisiana-Pacific on February 5, 1990 as a saw filer. On May 2, at the end of his 90-day probationary period, claimant was laid off. On May 18, claimant sought treatment from Dr. Carpenter for his arm numbness, reporting that his symptoms had worsened while working for Louisiana-Pacific. (Ex. 27-1). On June 5, Dr. Eisler diagnosed carpal tunnel syndrome, (Ex. 30-3), which was confirmed by neuroelectrophysiologic testing, (Ex. 31-1). On June 18, Dr. Carpenter placed claimant on "limited duty." (Ex. 32).

The record contains evidence that saw filing can cause carpal tunnel syndrome. (Ex. 48-9). Because claimant became disabled in June 1990 and the last potentially causal employment prior to that date was with Louisiana-Pacific, that employer is assigned initial liability for claimant's carpal tunnel syndrome. However, Louisiana-Pacific may shift responsibility to an earlier employer if it establishes that the work conditions with the prior employer were the sole cause of the disease or that it was impossible for work conditions during the period when the prior employer was on the risk to have caused the disease. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374 (1984). We conclude that Louisiana-Pacific failed to carry its burden of proof necessary to shift responsibility to SAIF's insured, Island City Saw.

The record contains two opinions regarding the contribution of work activities at Louisiana-Pacific to claimant's carpal tunnel syndrome. Based on claimant's history of the onset of symptoms, Dr. Eisler found that the major contributing cause of his condition was claimant's work at Island City Saw. (Ex. 48-23). Dr. Eisler further concluded that claimant's work at Louisiana-Pacific caused claimant's condition to become more symptomatic, (id. at 14, 18), and that, comparing his June 1990 electrical studies with those of Dr. Hendricks' in November 1990, there was evidence that the Louisiana-Pacific work had, at least transiently, worsened claimant's condition, (id. at 16). Dr. Eisler also had no "way of knowing for sure" whether or not the duration of claimant's work at Louisiana-Pacific was long enough to have caused "an irreversible pathologic change." (Id. at 19).

Dr. Strukel, SAIF's medical advisor, conducted a record review. Dr. Strukel concluded that claimant's carpal tunnel syndrome "not only worsened symptomatically, but pathologically" after working at Louisiana-Pacific. (Ex. 47-4). Dr. Strukel based his opinion on claimant's reports of hand swelling which he found "was associated with swelling of [claimant's] tenosynovium due to his work activities during that February through May 1990 period." (Id).

We conclude that the evidence is not sufficient to prove that claimant's work at Island City Saw was the sole cause of claimant's disease or that it was impossible that work at Louisiana-Pacific could have contributed to his condition. Dr. Strukel concluded that the Louisiana-Pacific work pathologically worsened claimant's condition; Dr. Eisler was unable to state that work at Louisiana-Pacific could not have contributed to claimant's condition and stated that the electrical studies show that there was at least a transient worsening. Therefore, we conclude that responsibility remains with Louisiana-Pacific.

Attorney Fees

Claimant asserts that the assessed fee of $2,200 awarded by the Referee at hearing should be increased to $4,000. Claimant bases this assertion on his attorney's efforts in establishing compensability and responsibility, which included solicitation of medical reports, participation in a deposition, and the time required to travel from Eugene to the hearing site in Pendleton.

After considering the factors contained in OAR 438-15-010(4), we find that the fee awarded by

the Referee should be increased. Furthermore, claimant's attorney is entitled to an assessed attorney fee for prevailing against Louisiana-Pacific's request for review. See ORS 656.382(2). After considering the factors in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing is $3,200 and on review is $1,400, to be paid by Louisiana-Pacific. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the record at hearing, claimant's respondent's brief and statement of services), the complexity of the issues, and the value to claimant of the interest involved. We note that claimant's attorney is not entitled to an attorney fee for services on Board review concerning the attorney fee issue.

ORDER

The Referee's order dated November 21, 1991 is affirmed in part and modified in part. In lieu of the Referee's attorney fee award, for services at hearing, claimant's attorney is awarded an assessed fee of $3,200. For services on Board review, claimant's attorney is awarded an assessed fee of $1,400, to be paid by Louisiana-Pacific.

August 31, 1992 Cite as 44 Van Natta 1739 (1992)

In the Matter of the Compensation of
MERIDEE A. KAIEL, Claimant
and CULTURAL HOMESTAY INSTITUTE, Noncomplying Employer
WCB Case Nos. 91-03467, 90-12953 & 90-20519
ORDER OF ABATEMENT
Schwabe, et al., Attorneys
Wallace & Klor, Attorneys
James Dodge (Saif), Defense Attorney

Claimant requests reconsideration of our August 12, 1992 Order on Review.

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

IT IS SO ORDERED.

August 31, 1992 Cite as 44 Van Natta 1739 (1992)

In the Matter of the Compensation of
KATHERN A. KNIGHTEN, Claimant
WCB Case No. 90-15985
ORDER ON RECONSIDERATION
Coons, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney
Employers Defense Counsel, Defense Attorneys

On June 22, 1992, we withdrew our May 22, 1992 order which: (1) vacated that portion of a Referee's order that addressed the appropriateness of a proposed carpal tunnel surgery; (2) reversed a portion of the Referee's order which held that a Determination Order was premature; and (3) affirmed an Order on Reconsideration award of 5 percent (7.5 degrees) scheduled permanent disability for each forearm. We took this action to consider the parties' proposed Disputed Claim Settlement (DCS).

We have now received the parties' DCS, which is designed to "compromise and settle the denied and disputed claims." Pursuant to the settlement, the parties agree that this matter shall be dismissed with prejudice. By this order, we have approved the parties' DCS, thereby fully and finally resolving this matter, in lieu of all prior orders. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
EASTER M. ROACH, Claimant
WCB Case No. 91-12263
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

The self-insured employer requests review of those portions of Referee Podnar's order that: (1) increased claimant's scheduled permanent disability award from 7 percent (10.5 degrees), as awarded by an Order on Reconsideration, to 22 percent (33 degrees) scheduled permanent disability for loss of use or function of her left forearm; and (2) directed the employer to pay claimant's scheduled permanent disability award at the rate of $305 per degree. On review, the issues are extent and rate of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt only the first paragraph of the Referee's "Findings."

CONCLUSIONS OF LAW AND OPINION

Extent of scheduled permanent disability

In determining the extent of claimant's scheduled permanent disability, the Referee relied upon the reports of Drs. Long and Button. On review, the employer first contends that Dr. Long's report is not admissible pursuant to ORS 656.268(5). We agree.

ORS 656.268(5) provides, 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."

Claimant argues that, because ORS 656.268(5) refers to "any medical evidence" that should have been submitted at the time of closure, the statute does not require exclusion of subsequent medical reports on the basis that they were not generated by an attending physician. We disagree.

As noted by claimant, we have previously found that, 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, we find that, pursuant to ORS 656.268(5), the term "any medical evidence" refers to evidence generated by claimant's attending physician at the time of claim closure. We find such an interpretation to be consistent with both our decision in Connor, supra and with the remainder of the language within the statute itself. ORS 656.268(5). Furthermore, we find that any decision to the contrary (e.g., that would permit the admission of evidence from IME's or other physicians) would contravene the statutory intent of ORS 656.245(3)(b)(B). Also see Agnes C. Rusinovich, 44 Van Natta 1544 (1992) corrected 44 Van Natta 1567 (1992) (a report from claimant's treating physician, although produced upon examination after claim closure, constituted for purposes of ORS 656.268(5), "medical evidence that should have been but was not submitted by the physician serving as the attending physician at the time of claim closure." (Emphasis added).

In the present case, claimant's attending physicians have been Dr. Browning and Dr. Layman. We find no evidence that Dr. Long was claimant's attending physician at the time of claim closure. Furthermore, claimant has not shown that her attending physicians either ratified the finding made by Dr. Long or incorporated those findings as his or her own. Under the circumstances, we conclude that

Dr. Long's report (indicating a loss of grip strength) may not be used for purposes of rating claimant's disability.

Finally, the Referee used the impairment findings of Dr. Button to support an award of 15 degrees loss of palmar flexion. However, as noted above, unless the attending physician at the time of closure ratified or adopted such a finding, an independent medical examiner's (IME) impairment finding may not be used for purposes of rating claimant's disability. Here, there is no evidence that the attending physician adopted the IME's report.

Because we find that claimant has not established an entitlement to an increased award of permanent disability, we reverse the Referee's order and affirm the Order on Reconsideration.

Rate of scheduled disability

The Referee concluded that claimant's award of scheduled permanent disability should be paid at the rate of $305 per degree. He relied on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), in which we held that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. Subsequent to the Referee's order, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992).

In this case, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury. ORS 656.202(2); former ORS 656.214(2).

ORDER

The Referee's order dated January 3, 1992 is reversed in part and affirmed in part. That portion of the Referee's order that increased claimant's scheduled permanent disability award to 22 percent (33 degrees) is reversed. The Order on Reconsideration is affirmed and claimant's total award to date is 7 percent (10.5 degrees) scheduled permanent disability for loss of use or function of her left forearm. That portion of the Referee's order that directed the self-insured employer to pay claimant's scheduled permanent disability award at the rate of $305 per degree is reversed. The employer is directed to pay claimant's scheduled permanent disability award at the rate in effect at the time of the compensable injury. The remainder of the Referee's order is affirmed.

August 31, 1992 Cite as 44 Van Natta 1741 (1992)

In the Matter of the Compensation of
JACK L. ROACH, Claimant
WCB Case No. 91-08554
ORDER ON RECONSIDERATION
Hollis Ransom, Claimant Attorney
Daryll E. Klein, Defense Attorney

On July 23, 1992, we issued an Order on Review which increased claimant's unscheduled permanent disability award from 20 percent to 23 percent. In doing so, we found that the preponderance of the evidence established that claimant's physical capacity is within the medium-light category, which, pursuant to former OAR 436-35-310(4), resulted in an adaptability value of 3.5. Thereafter, claimant moved for reconsideration. He asserted that the parties stipulated at hearing that his return to work restrictions were in the light to sedentary category. Based on this assertion, claimant argued that his adaptability value should be 8.

On August 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.

Although we agree with claimant that the parties stipulated at hearing as to his restrictions, we disagree that the adaptability value based on that stipulation is 8. The record establishes that the parties initially stipulated that the "correct calculation for his [claimant's] return to work should be light sedentary." (Tr. 17). However, the insurer's attorney clarified this as "[w]hat they used in the Determination Order." Id. Claimant's attorney agreed with that clarification. Id. "Light with restrictions" was the classification used in the Determination Order. (Ex. 25-2).

Claimant asserts that the parties' stipulation entitled him to an adaptability value of 8. However, that value is reserved for workers classified as "light-sedentary with restrictions" or "sedentary." Former OAR 436-35-310(4). Instead, both a "light-sedentary" classification and a "light with restrictions" classification are assigned an adaptability value of 6. Former OAR 436-35-310(4); WCD Admin. Order 15-1990. Thus, whether the parties stipulated to a "light-sedentary" classification or a "light with restrictions" classification, the correct adaptability value is 6.

Applying this corrected adaptability value, we proceed to calculate claimant's unscheduled permanent disability. The product of the value for claimant's age and education (5) and the value for claimant's adaptability (6) is 30. When that value is added to claimant's impairment value (5), the result is 35 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 35 percent, rather than 23 percent as we previously held.

Therefore, we increase claimant's unscheduled permanent disability award from 23 percent to 35 percent. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total attorney fees awarded by the Referee and Board orders shall not exceed $3,800.

Accordingly, our July 23, 1992 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our July 23, 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
NATHAN A. STEVENS, Claimant
WCB Case No. 90-13736
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Neidig and Brazeau.

Claimant requests review of those portions of Referee Lipton's order that: (1) upheld the insurer's de facto denial of claimant's dementia claim; and (2) found that a portion of claimant's medical services were not compensable. The insurer cross-requests review of that portion of the order that set aside its de facto denial of claimant's asthma claim. On review, the issues are compensability and medical services. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the last sentence.

CONCLUSIONS OF LAW AND OPINION

Compensability of dementia condition

The Referee concluded that claimant failed to prove that employment conditions were the major contributing cause of his dementia condition. He, therefore, concluded that the dementia was not

compensable. See ORS 656.802(2). In making this determination, the Referee gave more weight to the opinions of Drs. Rohila, Davies, and Gabr than that of claimant's treating physician, Dr. Feldstein.

Claimant asserts that the Referee wrongly concluded that the dementia condition was not compensable, in that the Referee relied on a report that was not admitted at hearing and should have given greater weight to Dr. Feldstein's opinion. We agree that the report of Dr. Gabr was not admitted at hearing. (Tr. 101, 103). We, therefore, have no authority to consider it on review. See Groshong v. Montgomery Ward Co., 73 Or App 403, 407 (1985). However, even without the opinion of Dr. Gabr, we agree with the Referee that claimant has failed to prove the compensability of his dementia condition.

The record contains three opinions regarding the causation of the dementia condition. After seeing claimant several times, Dr. Feldstein, industrial medicine specialist, became concerned that he was suffering from solvent encephalopathy as a result of occupational exposure to toxic substances. (Ex. 12-1). She referred claimant to Dr. Rohila, neuropsychologist. Dr. Rohila found that claimant's neuropsychological test results were "most consistent with a dementing condition" but that the results "by themselves are not enough to differentiate between Alzheimer's disease and toxic encephalopathy." (Ex. 13-6). Rohila suggested that another evaluation in 6 to 12 months "may be able to clarify the diagnostic picture much better[.]" (Id. at 7).

Claimant also was evaluated by Dr. Montanaro, professor at OHSU, for an independent medical examination. Montanaro agreed that claimant presented with "a very bothersome picture of dementia." (Ex. 18-7). Based on claimant's history, Montanaro opined that the condition likely "has multiple etiologies" including a depressive mood disorder and underlying intellectual impairment. (Id. at 6). Montanaro recommended an evaluation by a psychiatrist, "in order to more accurately assess his dementia." (Id. at 7). Dr. Feldstein concurred with Montanaro's report but added, "except solvent encephalopathy is in the differential for dementia." (Ex. 20).

Dr. Davies, clinical psychologist, conducted a second independent medical examination. Like Dr. Rohila, Davies administered psychological testing. Davies also concurred "with Dr. Rohila's findings that the test data suggests a dementing condition." (Ex. 25-7). He concluded that claimant "is suffering from a rather clear neuropsychiatric disturbance, the etiology of which remains unclear. He has rather clear signs of a Unipolar depression and significant cognitive disturbance." Davies noted that a recent MRI showed no definitive pathology, which would not "be expected in the case of solvent encephalopathy." (Id. at 10). Davies further stated that "the types of neuropsychological deficits [claimant] displays are not very consistent with the types of dementias seen secondary to depression," but that the deficits "are not very consistent with those typically found in a toxic encephalopathy." (Id. at 10-11). Davies concluded that "it seems obvious that the questions regarding causation * * * cannot be answered at the present time," and recommended referring claimant to a neuropsychiatrist. (Id. at 11).

Dr. Rohila disagreed with Davies' opinion that the negative MRI was proof that claimant did not suffer from solvent encephalopathy. (Ex. 35-1). Rohila did agree that the dementia was not consistent with that seen secondary to depression. (Id. at 2).

Dr. Feldstein testified at hearing that claimant suffered from dementia, the major contributing cause of which was his employment. (Tr. 43). She based this diagnosis on her conclusion that claimant had been exposed to toxic substances while painting, and that exposure to such substances had been shown to cause brain damage. (Id. at 69). She further explained that she had investigated and ruled out other possible causes of claimant's dementia. (Id. at 72). Feldstein "commit[ted] to a probability that this is not Alzheimer's and a probability that this is from exposure to solvents, [because] I just don't think that this has clinically acted like Alzheimer's thus far." (Id.) Feldstein also agreed with Dr. Rohila that a negative MRI did not rule out solvent encephalopathy, and stated that Dr. Davies' remark to the contrary indicated that he clearly was not "knowledgeable of the literature in that field." (Id. at 74).

We conclude from the medical evidence that claimant suffers from dementia. However, only Dr. Feldstein concludes that this condition is a result of claimant's work exposure. When the medical evidence is divided, we give greater weight to the conclusion of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 801, 814 (1983). Here, we find persuasive

reasons not to give greater weight to the opinion of Dr. Feldstein.

First, as a medical physician specializing in industrial medicine, Dr. Feldstein has no specialized training in diagnosing and treating neuropsychiatric conditions such as dementia. Although she apparently felt comfortable making such a diagnosis, we conclude from Dr. Montanaro's and Dr. Davies' opinions that the etiology of claimant's condition presents a complex medical issue requiring expert psychiatric evidence, including psychological testing. Because Feldstein has no training in psychology or psychiatry, she did not administer psychological tests or rely on such test results in rendering her opinion. We conclude that lack of psychological testing detracts from Feldstein's opinion.

As noted by claimant, both Drs. Feldstein and Rohila believed that Dr. Davies was wrong in stating that a negative MRI suggested that claimant did not suffer from solvent encephalopathy. Based on Davies' disagreement with Rohila, claimant asserts that Davies' report is not reliable. We conclude, however, that even if Davies was incorrect regarding the MRI results, his entire report should not be discredited. Neither Feldstein nor Rohila stated that Davies' administration and interpretation of the psychological tests were flawed. Rather, Rohila disagreed only with Davies' interpretation of the MRI results. We also note that Davies' ultimate conclusion, that it was premature to determine causation of claimant's dementia, is consistent with Rohila's ultimate conclusion. We, therefore, conclude that Dr. Davies' opinion is properly considered in determining the causation of claimant's dementia. We further conclude that on this record, claimant's condition is not compensable.

Compensability of asthma condition

Both Drs. Feldstein and Montanaro conclude that claimant has asthma. Both physicians explain that asthma can be occupationally caused by sensitizing agents, including diisocyanates and polyamides, both of which were used in claimant's work as a painter. (Tr. 79-80; Ex. 32-17). About 5 percent of persons exposed to diisocyanates develop asthma; that figure is less for persons exposed to polyamides. (Tr. 91-92; Ex. 32-17).

Drs. Feldstein and Montanaro disagreed, however, regarding the causation of claimant's asthma. Dr. Montanaro performed an allergy profile, a CT scan of the sinuses, and reviewed the material safety data sheets for claimant's work. He also examined claimant and obtained his medical history. Montanaro diagnosed chronic allergic rhinosinusitis, chronic infectious paranasal sinusitis and possible reactive airways disease (asthma) triggered by irritants, allergens, exercise, and, possibly, occupational exposure to multiple organic solvents, polyamines and hexamthylene diisocyanates. (Ex. 18-6).

Montanaro subsequently testified that claimant definitely had reactive airways disease. (Ex. 32-15). Montanaro could say only that occupational exposure had possibly contributed to claimant's asthma condition based on the number of known contributors in this case, including infections, irritants, exercise, and allergies. (Id. at 16-17). Montanaro also found that claimant's symptoms did not follow the usual pattern seen in asthma caused by sensitizers, because his symptoms had improved only slightly after being away from the workplace for a month. (Id. at 19-20). Montanaro further found it significant that claimant first sought treatment in May and June, "the major pollinating season for the environmental allergies" to which claimant is sensitive. (Id. at 25). Finally, Montanaro stated that the identified triggers aggravated claimant's symptoms but "that specific causation at this point is unknown." (Id. at 74).

Dr. Montanaro subsequently reiterated that, "given the nature and extent of [claimant's] exposures and his underlying coexisting conditions of infectious sinusitis and allergic rhinitis, it is my opinion that his occupational exposures resulted in transient aggravation of asthmatic symptoms. Occupational exposure to inhaled irritants in the vast majority of cases do not result in a change in the natural history of bronchial asthma." (Ex. 37-2) (emphasis in original).

In response, Dr. Feldstein stated that claimant's asthma was due to occupational exposure because it "did not exist before his work place exposure." She further felt "that [claimant] had enough exposure to cause the condition." (Id.)

Dr. Feldstein testified that her conclusion regarding causation was based on evidence that claimant "had not consistently worn a respirator during the time he's been a painter." She also was

advised that although claimant had consistently worn the respirator in the "last several years," it had not always fit properly because at times he wore a beard, the fit was not appropriate and it was not kept in proper condition." (Tr. 45). Feldstein examined claimant's respirator and found it to be dirty and not creating a proper seal. (Id. at 46). Claimant had reported to Feldstein that he had smelled paint fumes on multiple occasions while wearing the respirator and feeling "high" at least one time per day when he was painting. Feldstein found this to be further evidence that the respirator was not properly working. (Id. at 45).

Dr. Feldstein disagreed with Montanaro's opinion that claimant's allergies had played a more significant role than his work in causing asthma. Feldstein testified that claimant gave "a good history of work-relatedness of his asthmatic symptoms," in that he reported increased symptoms at work, then improvement on vacations and weekends. (Id. at 58-59). Feldstein also disagreed that claimant's minimal improvement after leaving work was evidence that his asthma was not occupationally caused; in her experience, Feldstein had found that "repeated episodes of bronchospasm would become less and less reversible over time" and that it took between "6 to 12 months to determine the amount of reversal." (Id. at 59, 60).

Dr. Feldstein further disagreed with Dr. Montanaro that infections played a role in claimant's asthma. She found it "questionable" that studies had shown asthma to be caused by bacterial infections. (Id. at 61).

In responding to Dr. Montanaro's findings of allergies, Dr. Feldstein explained that positive test results did not "necessarily suggest that [claimant] has symptomatic allergies from them." (Id. at 89-90). Feldstein later denied that claimant had a significant allergy problem. (Id. at 98). She also noted that claimant was seen once by Dr. Stibolt, pulmonologist, who diagnosed "probable occupational asthma." (Ex. 29-1).

After reviewing the record, we again find persuasive reasons not to give greater weight to the opinion of Dr. Feldstein. Weiland v. SAIF, supra. First, we find that Dr. Feldstein's opinion was based, in part, on an inaccurate history of claimant's work conditions. She understood that claimant painted about four hours of his work day and that the workplace contained one exhaust fan and one rotary fan, and a door was left open only when the weather allowed. (See Tr. 81-82). Claimant's foreman testified, however, that only about 10 percent of claimant's total work time was spent painting. (Id. at 15). About 85 percent of the painting was done on swing shift, while claimant worked on day shift. (Id. at 149). There was also testimony that the work place, a large building measuring 170 feet by 100 feet, contained two overhead fans, two exhaust fans in the wall, and three portable fans used for cross-ventilation. (Id. at 18). A large door was also kept open about 75 percent of the year. (Id. at 22).

We further conclude that Dr. Feldstein had an inaccurate history regarding claimant's actual exposure to those substances capable of causing asthma. For example, there is no evidence that Feldstein knew that the employer used a paint containing diisocyanates only in June 1990, and that claimant painted with this product for a total of two hours. (See id. at 28). In regards to claimant's respirator, there is evidence the employer was cited in 1988 by OSHA for failing to regularly clean and properly store respirators. (Ex. B-3). There is also evidence, however, that claimant's respirator worked properly. For instance, a check of the respirator by Sanderson Safety in August 1990 revealed a proper fit. (Ex. 14-1). Claimant's foreman also testified that claimant purchased a new respirator in 1989 in order to ensure a proper fit. (Tr. 38).

Neither did Dr. Feldstein adequately explain her reasons for rejecting any possible contribution by allergies and infections to claimant's asthma. The presence of allergies and infections was central to Dr. Montanaro's opinion that occupational irritants were the primary cause of claimant's asthma symptoms. We conclude that Feldstein did not fully consider these other possible contributors identified by Montanaro, or, if she did, she did not adequately explain why she disregarded them.

Finally, we find Dr. Stibolt's opinion to be unpersuasive; he saw claimant once and provided only a conclusory opinion regarding a complex condition.

We conclude that the medical evidence preponderates against a finding that claimant's asthma condition is compensable.

Medical Services

Claimant asserts that, even if the Board agrees with the Referee that claimant's dementia is not compensable, diagnostic services rendered by Dr. Rohila in relation to claimant's dementia are compensable. Claimant cites Jimmy K. Layton, 35 Van Natta 253 (1983), as support for his contention.

Under ORS 656.245(1)(a), "for every compensable injury," a worker is entitled to "medical services for conditions resulting from the injury[.]" The statute extends to payment of diagnostic services relating to noncompensable conditions if such procedures are performed to determine whether or not a causal relationship exists between the industrial injury and the noncompensable condition. See Brooks v. D & R Timber, 55 Or App 688, 691-92 (1982); Kenneth M. Simons, 41 Van Natta 378, 380 (1989); Chester L. Wing, 41 Van Natta 2433, 2435-36 (1989). Here, we have determined that claimant's dementia and asthma conditions are not compensable. In the absence of a compensable condition, claimant is not entitled to any medical services under ORS 656.245(1), including diagnostic services relating to his dementia condition.

Our order in Jimmy K. Layton, supra, does not compel a different result. There, the claimant sought payment under ORS 656.245 for exploratory surgery that would determine whether or not his hearing loss was related to the compensable injury. The Board concluded that the proposed surgery was compensable based on the treating physician's opinion of a possibility that the hearing loss was related to the industrial injury and the lack of evidence proving that the condition was unrelated. 35 Van Natta at 254. Contrary to claimant's assertions, the order does not hold that all diagnostic services are compensable if rendered to determine whether or not a condition is work-related.

Therefore, because the diagnostic services did not relate to a compensable injury, such procedures are not entitled to payment under ORS 656.245(1). Accord Charles L. Pratt, 42 Van Natta 2029, 2030 (1990) (services rendered for claimant's loss of consciousness episode were for an unrelated seizure disorder and not diagnostic services related to claimant's compensable injury).

ORDER

The Referee's order dated June 12, 1991, as amended June 18, 1991, is reversed in part and affirmed in part. Those portions of the order that set aside the insurer's de facto denial of claimant's asthma condition, awarded a $4,000 assessed attorney fee and assessed a 25 percent penalty for allegedly unreasonable claims processing are reversed. The remainder of the Referee's order is affirmed.

August 31, 1992 Cite as 44 Van Natta 1746 (1992)

In the Matter of the Compensation of
GARY R. THOMAS, Claimant
WCB Case No. 91-11382
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Robert Jackson (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

The SAIF Corporation requests review of those portions of Referee McWilliams' order that: (1) found that SAIF was entitled to offset on a dollar-per-dollar basis; and (2) directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree. Claimant cross-requests review of that portion of the order that found that SAIF was entitled to an offset. On review, the issues are offset and rate of scheduled permanent disability. We modify in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Offset

In 1984, claimant suffered a prior compensable injury to his left knee. He eventually was awarded 35 percent scheduled permanent partial disability. In 1989, claimant again suffered an injury to his left knee. SAIF accepted this claim. The February 20, 1991 Notice of Closure awarded claimant 32 percent scheduled permanent partial disability, but because claimant had previously been awarded 35 percent scheduled permanent partial disability, no additional permanent partial disability was awarded. The Notice of Closure was affirmed by an August 15, 1991 Order on Reconsideration.

The Referee found that based on medical evidence from claimant's treating physician, claimant had not completely recovered from a previous injury to his knee and, therefore, SAIF was entitled to an offset. Relying on City of Portland v. Duckett, 104 Or App 318 (1990), claimant asserts that his credible testimony established that he had completely recovered from his previous injury, thereby preventing SAIF from offsetting his current award from his previous award.

ORS 656.222 provides that for a claimant who has been awarded compensation for a permanent disability, "the award of compensation for such further accident shall be made with regard to the combined effect of the injuries of the worker and past receipt of money for such disabilities." The statute has been construed as allowing for the reduction of a scheduled disability award by the amount previously awarded for the same body part. See Norby v. SAIF, 303 Or 536, 540 (1987).

In City of Portland v. Duckett, supra, the Court of Appeals held that when a claimant establishes that there is, in fact, no combined effect between a previous and present injury, and that the claimant has completely recovered from the previous injury, ORS 656.222 does not apply. Therefore, there is no entitlement to offset. In determining whether or not the claimant in Duckett had completely recovered from the previous injury, the court noted the claimant's credible testimony that he had completely recovered. Further, none of the claimant's treating physicians mentioned the previous injury when discussing the claimant's present degree of disability in his knee. 104 Or App at 320.

Duckett does not support claimant's contention that his testimony alone is sufficient to establish whether or not he has completely recovered from his previous injury. Rather, we agree with the Referee that although claimant's testimony was probative, it could not supplant the medical evidence. See Uris v. Compensation Department, 247 Or 420, 426 (1967) (holding that complex medical case requires expert medical evidence). See also ORS 656.283(7) (requiring that impairment be established with medical evidence supported by objective findings).

In this case, the medical evidence establishes that claimant had not completely recovered from his previous injury when the present one occurred. It also establishes that his previous and present injuries combined. We, therefore, adopt that portion of the Referee's order. Therefore, ORS 656.222 is applicable and SAIF is entitled to an offset.

Next, SAIF contends that it is entitled to offset the previous award from the present one on a degree-per-degree basis, rather than a dollar-per-dollar basis as the Referee ordered. SAIF relies on former OAR 436-35-007(3) (WCD Admin. Order 20-1990) which provides:

> "Where a worker has a prior award of permanent disability under Oregon Workers' Compensation 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."

Claimant was declared medically stationary after July 1, 1990 and the Notice of Closure issued on February 20, 1991. Therefore, former OAR 436-35-007(3) is applicable to this case and SAIF is entitled to offset on a degree-per-degree basis. See former OAR 438-35-003 (WCD Admin. Order 20-1990); former OAR 438-35-003(2) (WCD Admin. Order 2-1991).

Claimant argues that the rule is inconsistent with ORS 656.222 and is, therefore, invalid. Specifically, claimant asserts that the phrase "past receipt of money" in ORS 656.222 indicates that offset

can be only a dollar-per-dollar basis. We disagree. We find that "past receipt of money" refers only to the claimant's previous award of temporary or permanent disability rather than providing a basis for offset. In fact, we find the statute to be silent as to the basis to be used for offset. Therefore, we conclude that former OAR 438-35-007(3) does not conflict with ORS 656.222.

Rate of scheduled permanent disability

The Referee concluded that claimant's award of scheduled permanent disability should be paid at the rate of $305 per degree. The Referee relied on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), in which we held that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. Subsequent to the Referee's order, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992).

In this case, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury. ORS 656.202(2); former ORS 656.214(2).

ORDER

The Referee's order dated December 19, 1991 is modified in part and reversed in part. That portion of the order requiring SAIF to pay claimant's scheduled permanent disability award at the rate of $305 is reversed. The February 20, 1991 Notice of Closure, as affirmed by the August 15, 1991 Order on Reconsideration (which awarded claimant no additional scheduled permanent disability) is affirmed. The remainder of the order is affirmed.

September 2, 1992 Cite as 44 Van Natta 1748 (1992)

In the Matter of the Compensation of
ROBERT J. EGYEDI, Claimant
WCB Case No. 91-07642
ORDER DENYING RECONSIDERATION
Schneider & DeNorch, Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our June 23, 1992 order that affirmed a Referee's order which awarded claimant's attorney a fee pursuant to ORS 656.386(1) when SAIF accepted claimant's right elbow and shoulder condition prior to hearing. Contending that a Claim Disposition Agreement (CDA) which was approved prior to our order resolved this matter, SAIF asserts that claimant's attorney is not entitled to the $750 award granted by our order.

SAIF has petitioned the Court of Appeals for judicial review of our order. ORS 656.295(8). Furthermore, the 30-day period within which to withdraw and reconsider our order has expired. SAIF v. Fisher, 100 Or App 288 (1990). Thus, jurisdiction over this matter currently rests with the court. ORS 656.295(8); 656.298(1). Nevertheless, at any time subsequent to the filing of a petition for judicial review and prior to the date set for hearing, we may withdraw an appealed order for purposes of reconsideration. ORS 183.482(6); ORAP 4.35; Glen D. Roles, 43 Van Natta 278 (1991). This authority is rarely exercised. Ronald D. Chaffee, 39 Van Natta 1135 (1987).

After review of the parties' respective positions, we decline to reconsider our June 23, 1992. However, we offer the following additional comments concerning SAIF's contention that the CDA resolved the issue of claimant's entitlement to an insurer-paid attorney fee for his counsel's efforts in prompting the rescission of SAIF's "de facto" denial of claimant's right elbow and shoulder condition prior to hearing.

As support of its assertions, SAIF relies on Randolph A. Krieger, 43 Van Natta 1656 (1991). In

Krieger, while an appeal of a Referee's order concerning a cervical condition and aggravation denial was pending Board review, the parties entered into a Disputed Claim Settlement (DCS) and a CDA. The DCS, which was approved by a Referee, resolved claimant's hearing request from a cervical surgery denial issued after the appealed Referee's order. The CDA, which received Board approval, settled claimant's "claim for compensation and payments of any kind due or claimed for the past, the present, and the future, except medical services." The CDA further provided that "all pending requests for hearing, if any, shall be dismissed with prejudice, as to all issues raised or raisable at this time."

In Krieger, we held that the DCS resolved the compensability issue concerning claimant's cervical condition. Furthermore, considering the reference in the CDA to any and all claims for compensation, we reasoned that the CDA included claimant's aggravation claim. Consequently, we concluded that claimant had released his rights to temporary disability benefits arising from the aggravation claim. Accordingly, we held that the issues pending Board review had been resolved.

Here, the CDA provides that the parties had settled "claimant's claim for compensation and payments of any kind due or claimed for all past, present, and future conditions, except medical services." The CDA further defines "compensation and payments of any kind due or claimed" to include "all past, present, and future temporary disability, permanent disability, vocational services, aggravation rights per ORS 656.273, and "Own Motion" rights per ORS 656.278 for any and all past, present and future conditions resulting directly or indirectly from this claim for occupational injury or disease, but does not include compensable medical services."

"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). Carrier-paid attorney fees do not constitute "compensation." Ernest C. Richter, 44 Van Natta 101 (1992), on recon 44 Van Natta 118 (1992).

As in Krieger, the present CDA contains a provision in which claimant releases his rights to past, present, and future compensation and payments of any kind. However, unlike Krieger, the issue pending Board review at the time of approval of the CDA was not a benefit to claimant resulting from a claim for compensation. Instead, the issue pending review was claimant's attorney's entitlement to an insurer-paid fee.

Inasmuch as such an attorney fee award is not compensation and is not a benefit to claimant, we hold that the CDA did not preclude claimant's attorney from receiving the $750 award. This conclusion is further supported by the fact that the CDA did not expressly settle the attorney fee dispute nor did the disposition contain a provision stating that all issues raised or raisable between the parties had been resolved.

Accordingly, SAIF's motion for reconsideration is denied. The issuance of this order neither "stays" our prior order nor extends the time for seeking review. International Paper Company v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 545 (1985).

IT IS SO ORDERED.

September 2, 1992 Cite as 44 Van Natta 1749 (1992)

In the Matter of the Compensation of
SCOTT S. HARDY, Claimant
WCB Case No. 90-04347
ORDER ON REVIEW
Drakulich & Carlson, Claimant Attorneys
Kevin Mannix, P.C., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Borchers' order that set aside its denial of claimant's July 2, 1990 low back surgery and current low back condition. On review, the issues are the propriety of the insurer's denial and compensability. We affirm.

FINDINGS OF FACT

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

Claimant suffered a prior compensable back injury at the employer in 1981. (Ex. 2). A lumbar CT scan performed on April 27, 1982 suggested a protruded disc at L4-5. (Ex. 3). An April 14, 1983 lumbar myelogram indicated the lumbar spine was normal. (Ex. 8). Claimant was released to regular work on July 5, 1983. (Ex. 8A). On July 27, 1983, claimant was involved in a motorcycle accident injuring his neck and his right knee. His low back symptoms did not change. (Ex. 9). As a result of his 1981 injury, claimant was awarded 20 percent unscheduled permanent disability. (Ex. 7). On October 12, 1984, Dr. Rosenbaum reported that claimant's disc protrusion at L4-5 had resolved. (Ex. 12).

Claimant suffered the injury at issue in this case on February 1, 1985 while moving a refrigerator. (Ex. 14). Dr. Schmidt diagnosed claimant's condition as lumbar strain with probable nerve root irritation on the left. (Ex. 14A). In a 1502 form, the insurer indicated that it was now accepting a previously deferred disabling injury. (Ex. 15E). On March 28, 1986, the insurer issued a partial denial of claimant's cervical and thoracic conditions as not related to the February 1985 compensable injury. That denial stated in part: "On February 1, 1985 you sustained an injury to your low back, and your physician diagnosed the condition as being lumbar strain with probable mild nerve root irritation on the left. This claim was accepted as a disabling claim * * *" (Ex. 35). Claimant has undergone three prior surgeries at L4-5 in relation to the February 1985 injury.

CONCLUSIONS OF LAW AND OPINION

Propriety of the Denial

We adopt the conclusions and reasoning concerning the propriety of the insurer's denial and the scope of the insurer's acceptance as set forth in the Referee's order with the following supplementation.

The Referee found that the insurer accepted claimant's L4-5 disc condition and was now estopped from denying the condition. On review, the insurer contends that its acceptance was limited to "back strain" and does not include claimant's L4-5 disc condition. We disagree.

Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). Acceptance of a claim encompasses only those conditions specifically or officially accepted in writing. Johnson v. Spectra Physics, 303 Or 49 (1987). Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability. ORS 656.262(9). However, where an insurer accepts a symptom of a disease, it also accepts the disease causing that symptom. Georgia Pacific v. Piwowar, 305 Or 494, 500 (1988).

Here, claimant suffered a compensable injury to his low back on February 1, 1985. He filed a claim for a strain injury to his lower left back. His physician diagnosed "lumbar strain" with "probable nerve root irritation left." The insurer indicated it was accepting the claim on a 1502 form without comment concerning the specific conditions accepted. When it accepted the claim, the insurer was aware that the condition was diagnosed as lumbar strain with probable mild nerve root irritation on the left. Moreover, when it later issued a partial denial of claimant's cervical and thoracic conditions in March 1986, it acknowledged that it had accepted claimant's February 1, 1985 injury diagnosed as lumbar strain with probable mild nerve root irritation on the left. Consequently, we agree with the Referee that the insurer accepted the nerve root irritation as well as lumbar strain. See Lawrence H. Eberly, 42 Van Natta 1965 (1990).

In Eberly, as in the present case, a claim for a back injury was deferred on a Form 801 and accepted on a 1502 Form. We said in Eberly, that neither the 801 nor the 1502 constituted an acceptance since the claim was deferred on the 801 and a Form 1502 is not an acceptance.[1] See EBI Ins. Co. v. CNA Insurance, 95 Or App 448 (1989). However, when the insurer in Eberly issued a partial denial of a cervical condition, it indicated it had accepted the specific condition of "lumbar strain." We found that this partial denial constituted an acceptance of the claim for lumbar strain. Likewise, in the present case we find that the insurer specifically accepted "lumbar strain with probable mild nerve root irritation on the left" in its partial denial of claimant's cervical and thoracic conditions.

We further find that the "nerve root irritation" resulted from the L4-5 disc bulge. On August 22, 1985, Dr. Storino, a neurologist at the Callahan Center noted probable L5 nerve root irritation, secondary to a protruded disc at the l4-5 level. (Ex. 24-4). On July 31, 1986, Dr. Brett compared a CT scan performed after claimant's February 1985 injury with A CT scan from 1982 and a myelogram performed in 1983. He concluded that claimant sustained a L4-5 lumbar disc protrusion as a result of his 1981 work injury and that claimant's February 1, 1985 injury pathologically worsened the L4-5 disc protrusion and caused the onset of radicular symptoms for the first time. Thus, when it accepted the nerve root irritation, the insurer also accepted the L4-5 disc condition which was the source of the nerve root irritation. It is now estopped from denying that condition. See Georgia-Pacific v. Piwowar, supra; Bauman v. SAIF, 295 Or 788 (1983).

Compensability of Current Condition

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

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 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 claimant's respondent's brief), the nature of the proceedings, the complexity of the issues, the value of the interest involved, and the risk that claimant's attorney's efforts might have gone uncompensated.

ORDER

The Referee's order dated April 15, 1991 is affirmed. For services on review claimant's attorney is awarded $2,000 payable by the insurer.

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[1] Based on our reading of the court's decision in EBI Ins. Co. v. CNA Insurance, supra, we assumed in Lawrence H. Eberly that a Form 1502 cannot constitute an acceptance under any circumstances. That understanding was wrong. Whether a claim has been accepted is a question of fact to be decided based on all the evidence. SAIF v. Tull, 113 Or App 449 (1992). Here, the insurer's brief states, and we find that the insurer, "issued a Form 1502 on March 19, 1985, indicating that the deferred injury claim was now accepted." (App. brief, p. 3). There is no evidence to the contrary. Thus, the insurer's March 28, 1986 partial denial (of the cervical condition) only served to clarify the scope of the prior acceptance.

In the Matter of the Compensation of
ROBERT G. HOPKINS, Claimant
WCB Case No. 91-10684
ORDER ON REVIEW
Richard McGinty, Claimant Attorney
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Kinsley.

Claimant requests review of Referee Myers' 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 affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had failed to timely request a hearing on a December 17, 1990 Determination Order. We agree.

A request for hearing must be filed within 180 days of the date the Determination Order is mailed; however, the time required to complete the mandatory reconsideration process is not included in that 180-day period. ORS 656.268(6)(b). OAR 436-30-050(3) provides that the 180-day time frame will be tolled "upon receipt of the request for reconsideration until the date the reconsideration order is issued." See Robert E. Payne Sr., 44 Van Natta 895 (1992).

In this case, the Determination Order was mailed on December 17, 1990. The Department received claimant's request for reconsideration on June 25, 1991, and issued its order on July 31, 1991. Thereafter, claimant filed a request for hearing on August 8, 1991. Accordingly, his request was beyond the 180 day limitation.[1]

Claimant argues that he had good cause for filing a late request, because he never received a copy of the Determination Order. He relies on case law interpreting ORS 656.319(1), which contains a good cause exception for filing a request for hearing on a denial of compensation. As recognized by the Referee, however, there is no statutory basis to allow a good cause exception under the facts presented here, which involve a request for hearing on a Determination Order. While there are similarities between the two situations, we are unwilling to fashion a remedy not provided for by statute. See Wright v. Benkins Moving & Storage, 97 Or App 45 (1989).

Even if we assume a good cause exception exists, we would nonetheless conclude that claimant has failed to establish a basis for relief from the statutory time limitation. Claimant relies on the fact he never received a copy of the Determination Order. The record reveals, however, that a copy of the December 17, 1990 Determination Order was mailed to claimant at his last known address and that, while claimant has lived at more than three different locations since filing his claim, he never notified SAIF of his change in address. Under those circumstances, we conclude that claimant has failed to establish good cause for his failure to file a timely request. See Charles R. Fritz, 43 Van Natta 403 (1991).

ORDER

The Referee's order dated November 26, 1991 is affirmed.

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[1] We note parenthetically that even if we were to find that the filing of claimant's request for reconsideration occurred on the date he mailed it, i.e., June 17, 1991, the request would still be untimely, having been made on the 181st day after the issuance of the Determination Order.

In the Matter of the Compensation of
DAVID JONES, Claimant
WCB Case No. 91-15537
ORDER ON REVIEW
Westmoreland, et al., Claimant Attorneys
Julie K. Bolt (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Kinsley.

The SAIF Corporation requests review of Referee Myers' order that awarded claimant's attorney an assessed attorney fee. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The sole issue is whether claimant's attorney is entitled to an assessed attorney fee for services rendered in obtaining a rescission of a disclaimer of responsibility. The Referee determined that he was

so entitled, finding that the disclaimer was the equivalent of a denial of a claim for compensation. We disagree and reverse.

The requirements of a notice of intent to disclaim responsibility are set forth in ORS 656.308(2), which provides, in part:

> "* * * Any employer or insurer which intends to disclaim responsibility for a given injury or disease claim on the basis of an injury or exposure with another employer or insurer shall mail written notice to the worker as to this position within 30 days of knowledge of being named or joined in the claim. The notice shall specify which employer or insurer the disclaiming party believes is responsible for the injury or disease. The worker shall have 60 days from the date of mailing of the notice to file a claim with such other employer or insurer. * * *"

From the plain language of that statute, it is clear that the purpose of a notice of intent to disclaim responsibility is purely procedural; i.e., it puts an injured worker on notice that his condition may be compensable against another employer and that he should file a claim with that employer. It is not intended to act as a denial of compensation, the procedures of which are contained in ORS 656.262(6). Moreover, OAR 438-05-053(2) and (4) expressly provide that if such a notice is intended to also serve as a denial, the notice must explicitly so state and provide the worker with complete denial rights. In this case, the notice contained no such language, but rather informed claimant that his claim was in deferred status.

Because SAIF's notice of intent to disclaim responsibility was not a denial of compensation, claimant's attorney is not entitled to an assessed fee under ORS 656.386(1). Further, even if we were to find that the notice was an actual denial of responsibility, a fee is not warranted, because "[i]f the employer denies responsibility, but not compensability, it has not denied a claim for compensation." Multnomah County School Dist. v. Tigner, 113 Or App 405 (1992).

ORDER

The Referee's order dated January 23, 1992 is reversed.

September 2, 1992 Cite as 44 Van Natta 1753 (1992)

In the Matter of the Compensation of
ROSE M. SHEPHERD, Claimant
WCB Case No. 91-13587
ORDER ON REVIEW
Dean Heiling, Claimant Attorney
Terrall & Associates, Defense Attorneys

Reviewed by Board Members Hooton and Brazeau.

The self-insured employer requests review of Referee Thye's order that awarded claimant additional benefits for temporary total disability. In its brief, the employer requests that we remand this matter for the taking of additional evidence. On review, the issues are remand and temporary disability. We deny the motion to remand and affirm.

FINDINGS OF FACT

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

On September 18, 1991, claimant requested a hearing, seeking additional temporary total disability benefits. The employer received a copy of the notice of hearing, but did not appear at the December 30, 1991 hearing. The next day, December 31, 1991, the Referee issued an order awarding claimant additional temporary total disability benefits and a penalty.

On January 13, 1992, the employer requested an abatement of the order and a reopening of the hearing. The Referee abated the order on January 16, 1992, but later found that the employer had failed to establish extraordinary circumstances to warrant postponement and republished his original order.

CONCLUSIONS OF LAW AND OPINION

Remand

The employer requests that we remand this matter to the Referee for the taking of further evidence concerning claimant's entitlement to temporary total disability benefits. It contends that this evidence is necessary, because claimant misrepresented facts with regard to whether she had been released to return to work.

We may remand to the Referee for the taking of additional evidence if we find that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). To merit remand, however, it must be shown that the evidence was not obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986). In this case, there is nothing in the record to suggest that this rebuttal evidence was not obtainable at the time of hearing. Rather, it appears that the evidence was available at the time of hearing and would have been submitted but for the employer's failure to appear. Because the employer offers no justifiable reason for not appearing at the hearing, we find no reason to conclude that the evidence was not obtainable with due diligence before the hearing. The employer's request for remand is denied.[1]

Temporary Total Disability

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

Attorney Fee on Review

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 is $800, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated January 29, 1992 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $800, to be paid by the self-insured employer.

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[1] We note that the employer also contends that it was prejudiced by the Referee's apparent failure to notify claimant as to her rights set forth in ORS 183.413(2). That argument lacks merit and we decline to address it.

In the Matter of the Compensation of
DOUGLAS A. EICHENSEHR, Claimant
WCB Case Nos. 91-00169 & 91-00168
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Davis & Bostwick, Defense Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Gruber's order that: (1) upheld Safeco Insurance Company's denial of his aggravation claim for a left shoulder condition; (2) upheld Kemper Insurance Company's denial of his "new injury" claim for the same condition; and (3) upheld Safeco's and Kemper's denials of his claims for a cervical condition. Safeco cross-requests review of those portions of the order that: (1) set aside its denial insofar as it denied medical services for the compensable shoulder condition; and (2) awarded claimant's counsel an allegedly excessive attorney fee for services in setting aside the medical services denial. On review, the issues are aggravation, compensability, medical services, and attorney fee. We affirm.

FINDINGS OF FACT

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

Claimant compensably injured his left shoulder on October 8, 1987 while employed by Safeco's insured. There is no evidence that he sustained a herniated cervical disc at that time. Dr. Grant performed EMG studies which revealed changes affecting the left brachial nerves of the shoulder only. X-rays taken on October 9, 1987, one day after the injury, revealed mild cervical spondylosis (degenerative changes of the cervical spine). Claimant has never evidenced any neurological deficit.

On October 3, 1990, while employed by Kemper's insured, claimant experienced increased left shoulder discomfort when he reached overhead to place an empty computer box on an overhead rack. Dr. Peterson, an associate of claimant's then treating physician Dr. Corson, prescribed anti-inflammatory medication and physical therapy for three weeks. Rather than claimant "returning" to work on October 25, 1990, we find instead that Dr. Peterson reported that claimant's symptoms had returned to their "ongoing level" by October 25, 1990. Claimant continued to work full-time at his usual and customary occupation from October 3, 1990 through December 1990, at which time he was taken off work pending evaluation of a possible cervical condition.

No ".307" order issued.

The last arrangement of compensation for claimant's left shoulder condition was the August 14, 1989 Determination Order. The order did not contemplate future periods of waxing and waning of symptoms.

On October 3, 1990, claimant experienced a symptomatic worsening of his left shoulder condition, supported by objective medical findings, since his last arrangement of compensation.

Claimant's symptomatic worsening of his left shoulder condition did not result in a diminished earning capacity.

The October 3, 1990 lifting incident is not a material contributing cause of the onset or worsening of claimant's left shoulder disability or need for treatment.

Neither the compensable October 1987 injury nor the October 1990 lifting incident is a material contributing cause of the onset or worsening of claimant's cervical condition or need for treatment.

CONCLUSIONS OF LAW AND OPINION

Compensability of Brachial Plexus Condition in October 1990

We agree with the Referee's ultimate conclusions that claimant has established neither a compensable aggravation of his 1987 brachial plexus injury, nor a new shoulder injury. However, we base our conclusions on the following analyses.

Aggravation

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 left shoulder condition, claimant must show that increased symptoms or a worsened underlying condition caused him to be less able to work, thus 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 worsening must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3). 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 last arrangement of compensation. ORS 656.273(8).

Claimant's left brachial plexus injury claim was closed by Determination Order on August 14, 1989. As a result of increased left shoulder pain, claimant presented to Dr. Peterson on October 4, 1990. The doctor noted diffuse tenderness and marked limitation of motion, and prescribed anti-inflammatory medication and physical therapy for three weeks. By October 25, 1990, claimant's condition had returned to its "ongoing" level of discomfort. Dr. Peterson opined that claimant had experienced a short-term symptomatic flare-up of his previous shoulder girdle strain. Claimant was later seen by independent orthopedic surgeon Dr. Perry and neurologist Dr. Kho in February 1991, and by independent orthopedic surgeon Dr. Donahoo in March 1991. These doctors reviewed claimant's prior medical records, and conducted thorough examinations. They concur that claimant experienced a symptomatic flare-up of his shoulder symptoms in October 1990. Thus, we find that claimant has established a symptomatic worsening of his compensable left shoulder condition, supported by objective findings.

However, claimant must also establish the worsening results in a diminished earning capacity. Here, Dr. Peterson did not take claimant off work due to his shoulder condition. Claimant continued to work full-time at his usual and customary occupation until December 1990, at which time he was taken off work pending evaluation of a cervical condition. Claimant's worsened shoulder condition has not resulted in a diminished earning capacity; accordingly, he has failed to establish a compensable aggravation. See Smith v. SAIF, supra.

New Injury (Brachial Plexus)

We also find that claimant has not sustained a new brachial plexus injury. The Referee applied ORS 656.005(7)(a)(B) to determine whether a new injury occurred at Kemper's insured. Subsequent to the Referee's order, we interpreted Section 49 of the amended law to mean that, in cases in which an accepted condition 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).

We have further held that ORS 656.005(7)(a)(B) is not applicable in the responsibility context because it does not determine compensability of the initial injury, but rather only limits a carrier's liability for continuing disability or need for medical services. Rosalie S. Drews, 44 Van Natta 36 (1992); Bahman M. Nazari, 43 Van Natta 2368 (1991). Moreover, we have explained that a prior, compensable injury does not constitute a preexisting disease or condition under ORS 656.005(7)(a)(B). Rosalie S. Drews, supra. Thus, in order to prove a "new compensable injury," Safeco had only to establish that the October 1990 incident at Kemper's insured was a material contributing cause of claimant's current disability or need for treatment. See Mark N. Wiedle, 43 Van Natta 855 (1991).

Following our de novo review of the record, we concur with the Referee that claimant did not suffer a new compensable brachial plexus injury while working for Kemper's insured. Drs. Peterson, Perry, Kho and Donahoo all opine that claimant experienced only a symptomatic flare-up of his previous shoulder girdle strain. Current treating neurosurgeon Purtzer does not diagnosis a new brachial plexus injury. Thus, claimant's work activities at Kemper's insured were not a material contributing cause of his shoulder disability or need for treatment. See Mark N. Wiedle, supra.

Medical Services

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 has original jurisdiction over questions regarding whether the need for medical service is causally related to the compensable injury. Michael A. Jaquay, 44 Van Natta 173 (1992).

In order to establish entitlement to medical services for the compensable left shoulder injury, claimant must prove a causal relationship between the medical services and the compensable injury and the reasonableness and necessity of the medical services. See ORS 656.245. Jordan v. SAIF, 86 Or App 29, 32 (1987); West v. SAIF, 74 Or App 317, 320 (1985).

On review, Safeco argues that the Referee should not have granted claimant any medical services benefits because he did not "present and pursue the .245 claim." On the contrary, Safeco specifically denied that claimant's "need for treatment . . . is the result of your original October 8, 1987 injury[.]" At hearing, claimant identified the issues as the insurers' three denials; on review, he again identifies the issue to be, inter alia, "the propriety of Safeco's January 2, 1991 denial[.]" Moreover, a claim for aggravation is a claim for compensation and medical services. See Joyce E. Mitts, 42 Van Natta 333 (1990). The issue of medical services was properly before the Referee.

In the case presented, Safeco does not challenge the reasonableness and necessity of the medical services; rather it contends only that the need for treatment is not the "result" of the compensable injury. Thus, the Board has jurisdiction over this medical services question. Michael A. Jaquay, supra. Based on our review of the record, we too find that claimant's need for treatment is causally related to the compensable left shoulder injury. Safeco remains responsible for medical treatment for claimant's compensable shoulder condition. See ORS 656.245.

Compensability of Cervical Condition

We adopt the Referee's reasonings and conclusion that claimant's cervical condition is not compensable, with the following comment.

On review, claimant continues to assert that the opinion of current treating physician Purtzer is more persuasive than those of examining physicians Perry, Kho and Donahoo. When there is a dispute between medical experts, the greater weight will be given to those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 262 (1986); See Hammons v. Perini Corp., 43 Or App 299, 302 (1979). The Board generally gives greater weight to the conclusions of a treating physician, unless there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds, 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986). Here, we find there are such reasons.

Dr. Purtzer is a new attending physician; he first examined claimant in December 1990. Independent examiners Drs. Perry and Kho, and Dr. Donahoo, examined claimant in February 1991 and March 1991 respectively. Thus, Dr. Purtzer's status as attending physician gives him no special advantage with regard to the issue of causation and, thus, we give no special deference to his opinion based on his status as an attending physician. See David E. Gates, 40 Van Natta 798 (1988).

Claimant was referred to Dr. Purtzer when December 1990 cervical spine x-rays, CT and myelographic studies revealed progression of claimant's cervical spondylosis. Dr. Purtzer opines that claimant most likely suffered a ruptured disc during the 1987 injury which has since calcified, causing the cervical spondylosis. There is, however, no evidence in the record (apart from Dr. Purtzer's stated

opinion) that claimant has ever sustained a herniated disc. At his deposition, Dr. Purtzer testified that he did not have claimant's early medical records for review, nor was he aware that October 9, 1987 x-rays showed degenerative changes of the cervical spine. Dr. Purtzer further testified that he "surmises" a disc injury occurred on October 8, 1987 based on the patient's history of the event. He explained that he made "a lot of assumptions . . . and hypotheses . . .," and reasoning "backwards," concluded that the October 1987 injury was the cause of claimant's cervical spondylosis.

We find that Dr. Purtzer has failed to explain the relative contribution of the degenerative changes that existed prior to the compensable injury. Neither has he addressed Dr. Donahoo's opinion that, given the disparity between claimant's symptom presentation and the radiological findings, the x-ray changes represent "incidental" findings that have no clinical significance. For these reasons (including Purtzer's reliance on assumptions and surmise), we too find Dr. Purtzer's opinion not to be persuasive and decline to rely on it.

On the other hand, we find Drs. Perry, Kho, and Donahoo's opinions to be better explained. These physicians reviewed claimant's prior medical records, took complete histories, and conducted thorough examinations. The doctors concede that if claimant had no prior history of degenerative changes, the October 1987 injury could have been the precipitating event for claimant's spondylosis. Noting, however, that cervical spondylosis is a slowly progressive degenerative condition, and that claimant already evidenced cervical spondylosis one day after his compensable 1987 injury, they opine that claimant's spondylosis has no relationship to that injury. The Referee did not err in relying on the well-reasoned opinions of Drs. Perry and Kho. See Somers, supra.

Attorney Fees At Hearing

Finally, Safeco contends that the Referee's attorney fee award for claimant's counsel's services in setting aside its medical services denial was excessive. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we agree with the Referee that a reasonable assessed attorney fee for claimant's counsel's services at hearing is $1,500, to be paid by Safeco. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record) and the value of the interest to claimant. Accordingly, we affirm the Referee's $1,500 attorney fee award.

Claimant's attorney is entitled to a reasonable assessed fee for his services on review defending against Safeco's cross-appeal for disallowance of medical services. ORS 656.382(2). After considering the same factors set forth above, we find that a reasonable assessed attorney fee for claimant's counsel's services on review concerning the compensability of medical services issue is $500, to be paid by Safeco. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's cross-respondent's brief), the complexity of the issue, and the value of the interest involved. Inasmuch as attorney fees are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for services on review concerning the Referee's attorney fee award. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated September 5, 1991 is affirmed. For services on review concerning the compensability of medical services issue, claimant's counsel is awarded a reasonable attorney fee of $500, payable by Safeco Insurance Company.

September 9, 1992 Cite as 44 Van Natta 1758 (1992)

In the Matter of the Compensation of
MARIA O. GARIBAY, Claimant
WCB Case No. 91-16677
ORDER OF DISMISSAL (REMANDING)
Michael B. Dye, Claimant Attorney
Kevin L. Mannix, P.C., Defense Attorneys

The insurer has requested Board review of Referee Michael Johnson's August 11, 1992 and August 21, 1992 orders. We have reviewed the request to determine whether we have jurisdiction to consider it. We conclude that jurisdiction rests with the Hearings Division.

FINDINGS OF FACT

The Referee's Opinion and Order issued August 11, 1992. On August 14, 1992, the insurer requested that the Referee reconsider his decision. On August 18, 1992, claimant responded to the insurer's request.

On August 21, 1992, the Referee issued an Order on Reconsideration. The Referee adhered to and republished his August 11, 1992 order. Thereafter, the Referee received further arguments concerning the matters in dispute from both parties.

On August 27, 1992, the Referee issued an Order of Abatement to consider the insurer's and claimant's additional responses. That same day, the Board received the insurer's request for review of the Referee's August 11, 1992 and August 21, 1992 orders.

CONCLUSIONS OF LAW

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

Here, the Referee abated his orders on August 27, 1992. That same day, the insurer's request for Board review of the Referee's orders was received by the Board. Inasmuch as the Referee abated his orders simultaneously with the insurer's request for Board review, we shall give effect to the Order of Abatement. Accordingly, the request for Board review is dismissed as premature. This matter is remanded to Referee Michael Johnson for further consideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
GREGORY S. MYERS, Claimant
WCB Case No. 91-15649
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Menashe's order which declined to reclassify claimant's injury claim as disabling. On review, the issue is reclassification. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant was not entitled to have his claim reclassified as disabling. We agree.

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 here is not subject to a special exception to the Act's general applicability provision. 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, this matter is appropriately analyzed under the workers' compensation law as amended, effective July 1, 1990.

On Board review, the insurer contends that the Referee lacked jurisdiction to decide this issue because claimant had not first requested reclassification from the Evaluation Division. Claimant argues that the Referee had jurisdiction to rule on his request for reclassification because his claim was initially misclassified by the insurer as nondisabling, or, in the alternative, because Dr. Filarski's January 1990 chart note notified the insurer that claimant's claim had become disabling. We conclude that the Referee had jurisdiction to decide this matter but we reach that conclusion based on the following analysis.

In 1990, the legislature added ORS 656.277 to Chapter 656. ORS 656.277 provides:

"Claims for nondisabling injuries shall be processed in the same manner as claims for disabling injuries, except that:

(1) If within one year after the injury, the worker claims a nondisabling injury is disabling, the insurer or self-insured employer, upon receiving such a claim shall report the claim to the director for determination pursuant to ORS 656.268.

(2) A claim that a nondisabling injury has become disabling, if made more than one year after the date of injury, shall be made pursuant to ORS 656.273 as a claim for aggravation.

(3) A claim for a nondisabling injury shall not be reported to the director by the insurer or self-insured employer except:

(a) When notice of claim denial is filed;

(b) When the status of the claim is as described in subsection (1) or (2) of this section;

(c) When the worker objects to a decision that the injury is nondisabling and requests a determination thereon; or

(d) When otherwise required by the director."

We have interpreted ORS 656.277 to require a claimant to seek reclassification from the Evaluation Division prior to seeking a hearing on that issue. Christine A. Degrauw, 44 Van Natta 91 (1992). In Degrauw we held that the Hearings Division, and consequently the Board, does not have jurisdiction over a request for reclassification unless claimant first exhausts administrative remedies provided in ORS 656.277(3)(c), by requesting reclassification from the Evaluation Division. Id. at 92. However, we also stated that ORS 656.277(3)(c) does not restrict claimant to a time limit in which to contend that a nondisabling claim has become disabling. Id.

Although we continue to adhere to our holding in Degrauw, we offer the following clarification. ORS 656.277(3)(c) does not restrict claimant to a time limit in which to contend that a nondisabling claim has become disabling. However, ORS 656.277(2) and ORS 656.273(4)(b) both provide that if a claim that a nondisabling injury has become disabling is made more than a year after the date of injury, the claim shall be made as an aggravation pursuant to ORS 656.273. Therefore, ORS 656.277(2) and ORS 656.273(4)(b) restrict the Evaluation Division's jurisdiction to requests for reclassification made within one year from the date of injury. Conversely, after the one year period, a reclassification request is made as an aggravation claim. See Corinne K. Freeman, 44 Van Natta 495 (1992).

Here, claimant was injured on October 1, 1989. He did not specifically request reclassification until his August 1991 Request for Hearing, more than a year from the date of injury. Consequently, pursuant to ORS 656.277(2) and ORS 656.273(4)(b) his claim must be treated as a claim for aggravation under ORS 656.273. The Hearings Division had jurisdiction over that claim.

Reclassification/Aggravation

In reaching this conclusion, we necessarily reject claimant's contention that the Referee's jurisdiction depends on whether the claim was originally misclassified. In 1990, ORS 656.273(4)(b) was

amended to provide: "If the injury has been in a nondisabling status for one year or more after the date of injury, the claim for aggravation must be filed within five years after the date of injury." (Emphasis added). Former ORS 656.273(4)(b) provided: "If the injury was nondisabling and no determination was made, the claim for aggravation must be filed within five years after the date of injury." (Emphasis added).

Thus, under the statute as amended, the question has changed from whether the injury was in fact nondisabling at the outset to whether the injury had been in a "nondisabling status" for more than a year. If so, the claim must be brought as an aggravation under ORS 656.273. We have previously noted that the "new law" effectively eliminated the rationale behind Davison v. SAIF, 80 Or App 541 modified on recon 82 Or App 546 (1986). See Oliver M. Payton, 43 Van Natta 2738, 2739 (1991). In Davison a distinction was drawn between a claim that an injury was misclassified as non-disabling at the outset and a claim that a nondisabling injury had become disabling. In the latter circumstance, the claim was subject to the one year time limitation set forth in former ORS 656.262(12) while a claim that an injury had been disabling at the outset was subject to no such time limitations.

After the amendments to ORS 656.273(4)(b), and the addition of ORS 656.277, there is no longer a distinction between an injury that was initially misclassified as nondisabling and an injury which was nondisabling but which has become disabling. After the passage of one year, both claims must be made as aggravation claims. See ORS 656.277; ORS 656.373(4)(b). Here, as noted above, claimant did not seek reclassification of his injury from nondisabling to disabling within one year of his injury; therefore, the claim must be made as an aggravation. Corinne K. Freeman, supra; ORS 656.273(4)(b); ORS 656.277(1) and (2).

Here, claimant's request for reclassification was based on Dr. Filarski's January 5, 1990 chart note. Accordingly, we must decide whether Dr. Filarski's chart note was sufficient to constitute a claim for an aggravation under ORS 656.273(3). That statute provides: "A physician's report establishing the worsened condition by written medical evidence supported by objective findings is a claim for aggravation." We have held that to constitute an aggravation claim, under this statute "the physician's report must be sufficient to constitute prima facie evidence in the form of objective findings that claimant's compensable condition has medically worsened." Glean A. Finley, 43 Van Natta 1442, 1444; Herman M. Carlson, 43 Van Natta 963, 964 (1991). Moreover, the report must draw a causal connection between claimant's noted condition and the compensable injury. Herman Carlson, supra.

Here, Dr. Filarski's chart note states:

> "Complete modified work activity in the next 1 month. After that the patient plans to move and obtain different work. I believe the patient can be considered medically stationary. He has no functional disability and should be maintained at light duty work activities because of the nature of his job at this time. Patient has a likelihood of recurrence depending upon future activity."

This chart note does not constitute prima facie evidence that claimant's compensable condition has worsened. Thus, the chart note does not constitute an aggravation claim under to ORS 656.273(3).

ORDER

The Referee's order dated November 26, 1991, as amended December 23, 1991, is affirmed.

In the Matter of the Compensation of
JOAQUIN M. BETANCOURT, Claimant
WCB Case No. 91-17268
ORDER ON REVIEW
Richart F. McGinty, Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

The insurer requests review of Referee Quillinan's order that awarded claimant 3 percent (9.6 degrees) unscheduled permanent disability for a thoracic condition, whereas an Order on Reconsideration awarded none. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the "OPINION" section of the Referee's order, with the following modification.

The Referee concluded that, because claimant challenged her attending physician's impairment findings on reconsideration before the Director and a medical arbiter was appointed to evaluate the level of claimant's impairment, the findings of the arbiter are conclusive and supercede the findings of claimant's physician's findings. We disagree.

Subsequent to the Referee's order, we have held that ORS 656.268(7) does not mandate that only the medical arbiter's findings be considered in evaluating the level of claimant's impairment. Timothy W. Reintzell, 44 Van Natta 1534 (1992) (held that a Director's rule, which mandated that impairment be established only by the medical arbiter's findings, exceeds statutory authority and is of no effect). Rather, we noted that ORS 656.726(3)(f)(B) provides that under the standards for rating permanent disability, "[i]mpairment is established by a preponderance of medical evidence based upon objective findings." Therefore, interpreting ORS 656.268(7) consistently with ORS 656.726(3)(f)(B), we concluded that the level of claimant's impairment is established by the preponderance of medical evidence, considering the medical arbiter's findings and any prior impairment findings. Id.

Here, Dr. Foster, the attending physician, found claimant medically stationary without permanent impairment. (Ex. 3). On the other hand, Dr. Strum, the medical arbiter, found mild limitation on claimant's ranges of thoracic motion. (Ex. 7-2). Although Dr. Strum noted some pain behavior and questioned whether claimant's efforts were truly maximal, we are not persuaded that those comments alone are sufficient to undercut the accuracy of his objective findings.

After reviewing the aforementioned opinions, we are most persuaded by Dr. Strum's findings of reduced ranges of motion. In this regard, we note that, on claimant's last visit to Dr. Foster prior to becoming medically stationary, Dr. Foster noted that claimant would continue to have intermittent symptoms which would not improve with further therapy. (Ex. 2). This note suggests some degree of permanent physical impairment, notwithstanding the doctor's later conclusion that there was none. Accordingly, we conclude that a preponderance of the medical evidence establishes that claimant has sustained permanent losses of range of motion, for which he is entitled to an award of 3 percent unscheduled permanent disability.

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 extent of unscheduled permanent disability is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 25, 1992 is affirmed. Claimant's attorney is awarded $500 for services on Board review, to be paid by the insurer.

In the Matter of the Compensation of
FRANCES I. CLINTON, Claimant
WCB Case No. 91-15647
ORDER ON REVIEW
Rick W. Roll, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Hooton and Brazeau.

Claimant requests review of Referee Menashe's order that dismissed her request for hearing on the ground that the request was untimely. On review, the issue is propriety of the dismissal. We affirm.

FINDINGS OF FACT

On July 25, 1982, claimant sustained a compensable back injury while working for the employer, who was insured by Fremont Indemnity Company. Claimant's claim was processed as disabling and a January 27, 1984 Determination Order closed her claim. Claimant later sustained two compensable injuries while working for subsequent employers.

In early 1991, claimant's condition worsened and she filed claims against the subsequent employers. The subsequent employers denied the claim and, under a "Disclaimer of Responsibility," the subsequent employers informed claimant that she must file a claim with her first employer, Fremont's insured.

On June 25, 1991, claimant filed an aggravation claim with her first employer. The employer did not accept or deny her claim.

On October 28, 1991, claimant requested a hearing from the first employer's "de facto" denial of aggravation. Claimant's hearing request identified the issues as aggravation and penalties. On November 19, 1991, the Referee issued an order of dismissal that dismissed claimant's request for hearing against the first employer, on the ground that claimant's aggravation rights had expired.

CONCLUSIONS OF LAW AND OPINION

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

On review, claimant does not dispute the Referee's ruling regarding the expiration of her aggravation rights. However, claimant contends that her aggravation claim also consisted of a medical services component.

We find that claimant did not raise the issue of medical services or a "de facto" denial of medical services in her request for hearing. Accordingly, we decline to address the issue for the first time on review. See Mavis v. SAIF, 45 Or App 1059 (1980). However, we note that, because no denial of medical services has issued, our decision in this matter has no preclusive effect over claimant's further assertions to entitlement to medical services.

Finally, although the Referee referred to claimant's request for hearing as untimely, we find that, because the aggravation denial consisted of a "de facto" denial, the request for hearing could not have been untimely. Rather, we find that it was the aggravation claim itself that was untimely.

ORDER

The Referee's order dated November 19, 1991 is affirmed.

In the Matter of the Compensation of
SHIRLEY J. DAVIS, Claimant
WCB Case No. 91-08302
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Cooney, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of that portion of Referee Podnar's order that declined to award scheduled permanent disability for her upper extremities condition. In its brief, the self-insured employer contends that the Referee erred by admitting Exhibit 61 into evidence. On review, the issues are evidence and extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

On review, the employer contends that the Referee should not have admitted into evidence Exhibit 61, which is Dr. Berkeley's, claimant's attending physician's, response to a questionnaire from claimant's counsel pertaining to permanent impairment ratings. The employer argues that, because the report was not submitted until approximately five months after the date of closure, it should be excluded pursuant to ORS 656.268(5). We disagree.

We recently held that a Referee may admit into evidence a report from a treating physician that was produced after claim closure, if the report is evidence that should have been but was not submitted by the physician serving as the attending physician at the time of claim closure. Agnes C. Rusinovich, 44 Van Natta 1544 (1992). Here, we find that the report from claimant's attending physician, Dr. Berkeley, constitutes such evidence.

We do not agree with the employer's argument that, because the report was not prepared until after closure, it cannot equate to evidence that should have been submitted at that time. (Here, although Dr. Berkeley referred to the fact that he had completed Exhibit 61 in reliance upon full neurological evaluations carried out in March and April of 1991, we agree with claimant and the Referee that the record indicates that Dr. Berkeley was actually relying upon exams performed in March and July, 1990. (Exs. 67, 41, 48 and 53). Because Dr. Berkeley answered the questionnaire based upon neurological examinations performed before claim closure, we agree with the Referee that Exhibit 61 consists of medical evidence that should have been admitted at the time of claim closure.

Under the circumstances, we conclude that the Referee did not err by admitting Exhibit 61 into evidence.

Extent of scheduled disability

On review, claimant disagrees only with that portion of the Referee's order that declined to award scheduled permanent disability for her upper extremities condition. Claimant argues that the Referee incorrectly found that there was no medical evidence regarding scheduled permanent disability, as Exhibit 61 contains Dr. Berkeley's findings that claimant has ratable scheduled permanent impairment.

We conclude that, although Dr. Berkeley's report is evidence of scheduled permanent impairment, it is not persuasive evidence. In December 1989, Dr. Fuller, independent medical examiner, found that claimant's lumbosacral and cervical strain had resolved. He declared claimant to be medically stationary without permanent impairment. On July 25, 1990, Dr. Berkeley agreed with Dr. Fuller's report with the exception of the diagnosis of strain/sprain. Rather, he diagnosed a mild lesion at C5-6 with a moderate disc bulge. He agreed, however, that claimant was medically stationary, and found that she had only "very mild residuals."

In Dr. Berkeley's response to claimant's questionnaire, he found that claimant had loss of sensation, decreased grip strength, loss of arm strength due to spinal nerve injury and chronic conditions limiting the repetitive use of both hands and both arms. Claimant has argued that Dr. Berkeley's findings suggest a scheduled award of 49 percent for each arm.

We conclude that, because Dr. Berkeley initially found claimant's condition to be resolved with minimal impairment, his subsequent findings, which claimant argues would support a scheduled award of 49 percent for each arm, are inconsistent. Accordingly, without further explanation from Dr. Berkeley, we do not find his report to be persuasive evidence of permanent scheduled impairment.

Instead, we are persuaded by the findings of Dr. Gardner, the medical arbiter appointed by the Director, which do not support an award of scheduled permanent disability. (Ex. 63A). Consequently, we conclude that a preponderance of the evidence does not support a scheduled disability award. See ORS 656.726(3)(f)(B).

We, therefore, affirm the Referee on the issue of extent of scheduled impairment.

ORDER

The Referee's order dated October 8, 1991 is affirmed.

September 10, 1992 Cite as 44 Van Natta 1765 (1992)

In the Matter of the Compensation of
WILLIAM M. MUELLER, Claimant
WCB Case No. 91-12401
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of Referee Mills' order which: (1) found that the Hearings Division had jurisdiction over a dispute concerning the interpretation of a Stipulated Order; (2) set aside its denial of claimant's chiropractic care; and (3) awarded an assessed attorney fee with respect to the denial of medical services. On review, the issues are jurisdiction, medical services and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

On review, the insurer argues that the Referee did not have jurisdiction over this matter, and amended ORS 656.245 has mandated that palliative care is no longer compensable. We disagree with the insurer's jurisdictional argument.

We conclude that the Referee's analysis of this case is consistent with our decision in Kevin A. Haines, 43 Van Natta 1041 (1991). Moreover, subsequent to the Referee's order, we issued our decision

in Patrick E. Riley, 44 Van Natta 281 (1992). In Riley, the stipulation provided that "claimant shall treat with a psychiatrist for the mental portion of this claim." Additionally, in Riley, we found that the stipulation made no reference to any statute or administrative rule. Rather, the dispute solely concerned the meaning and appropriate application of the terms of the Stipulated Order. Riley, supra. Accordingly, we concluded that, for purposes of ORS 656.704(3), there was no other procedure for resolving the dispute and, therefore, jurisdiction existed with the Hearings Division.

We find that the facts of the present case are analogous to the facts of Riley. Here, the stipulated order provided only that "claimant shall be entitled to chiropractic care for two more visits in December, for four visits in January and February, and for two visits per month thereafter, so long as his care is palliative." Under the circumstances, we agree with the Referee that the stipulation makes no reference to any statute or administrative rule. Accordingly, because the dispute solely concerns the meaning and appropriate application of the terms of the stipulated order, we conclude that there is no procedure otherwise provided in ORS Chapter 656 for resolving the dispute. Therefore, the Hearings Division had jurisdiction to enforce this stipulation.

Medical services/attorney fees

We adopt the Referee's conclusions and opinion on the issues of medical services and attorney fees.

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 on Board 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) and the value of the interest involved.

ORDER

The Referee's order dated December 20, 1991 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the insurer.

September 10, 1992 Cite as 44 Van Natta 1766 (1992)

In the Matter of the Compensation of
EDNA E. McNULTY, Claimant
WCB Case No. 91-04915
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of Referee Poland's order that upheld the self-insured employer's acceptance of claimant's carpal tunnel syndrome condition as an aggravation. On review, the issue is whether the claim should be characterized as an occupational disease or aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In 1989, the employer was ordered to accept a claim for bilateral carpal tunnel syndrome. After the claim closed in March 1990, claimant returned to work and experienced increased symptoms. In April 1991, she filed a claim for her current left hand condition. The employer denied the claim as an occupational disease but accepted it as an aggravation. The Referee found that the claim was properly characterized as one for aggravation. Claimant asserts that the claim should be treated as an occupational disease.

"Occupational disease" is defined as "any disease or infection arising out of and in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed[.]" ORS 656.802(1). Moreover, employment conditions must be the major contributing cause of the disease or its worsening. ORS 656.802(2).

"Aggravation" is a "worsened condition[] resulting from the original injury." ORS 656.273(1). A worsened condition is established with evidence of increased symptoms or a worsened underlying condition and a resultant diminishment of earning capacity since the last arrangement of compensation. See Leroy Frank, 43 Van Natta 1950 (1991).

ORS 656.802(1) requires that an occupational disease be established by a showing that job activities contributed to the disease or its worsening. An aggravation claim, on the other hand, merely requires that the worsening, be is symptomatic or otherwise, result from the original injury. Thus, an occupational disease is established only where it is shown that job conditions independently contributed to a worsening of the underlying condition. Accord Raymun B. Savalas, 42 Van Natta 2582 (1990); Teresa L. Walker, 41 Van Natta 2283 (1989).

As the Referee found, claimant failed to show that her job activities subsequent to the closure of her initial claim contributed to her underlying left hand condition. Claimant's treating physician, Dr. Wells, opined that claimant's job activities had contributed to her increased symptoms, but he stated that it was "unknown" whether her job had independently contributed to a pathological worsening of her condition. (Ex. 28-1).

Therefore, we conclude that claimant's increased symptoms were a result of her initial injury rather than her subsequent work exposure. Thus, the claim is properly characterized as one for aggravation rather than occupational disease.

ORDER

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

September 10, 1992 Cite as 44 Van Natta 1767 (1992)

In the Matter of the Compensation of
PATRICIA A. RUMPCA, Claimant
WCB Case No. 91-11503
ORDER ON REVIEW
Robert J. Thorbeck, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Herman's order that affirmed a Determination Order award of 23 percent (73.6 degrees) unscheduled permanent disability, thereby reducing a subsequent Order on Reconsideration which had awarded 45 percent (144 degrees) unscheduled permanent disability for her low back condition. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

On review, claimant disagrees with only that portion of the Referee's order that assigned an adaptability value of 2. Claimant disagrees with the Referee's finding that she had returned to modified work. She argues that her testimony establishes that the employer's modified work offer was a sham. Specifically, claimant contends that the employer hired her to perform work as a telephone operator and then laid her off after a month.

We do not agree that claimant's testimony proves that the modified work position was a ruse or was made in bad faith. At the time of her injury, and during her modified work, claimant was employed as a flex force worker, which is an on-call temporary position. However, due to a lack of need for such workers at that time, the employer subsequently "disbanded" the pool of workers that performed the same type of work as claimant. (Ex. 15-2).

We conclude that claimant has failed to prove either that her modified work offer was not valid or that she was laid off because of her injury or her workers' compensation claim. Accordingly, we agree with the Referee's conclusion that claimant left work for reasons unrelated to her injury. See Cleophas C. Chambliss, 43 Van Natta 904 (1991)(Claimant was not working at the time of determination because her job ended, not as a result of her compensable injury).

ORDER

The Referee's order dated December 12, 1991 is affirmed.

September 10, 1992 Cite as 44 Van Natta 1768 (1992)

In the Matter of the Compensation of
WILLIAM L. THOMPSON, Claimant
WCB Case No. 91-07241
ORDER DENYING RECONSIDERATION
Bischoff & Strooband, Claimant Attorneys
Wallace & Klor, Defense Attorneys

On July 22, 1992, we issued an Order on Review which: (1) affirmed that portion of a Referee's order which assessed a penalty for the self-insured employer's refusal to pay claimant's scheduled permanent disability award; and (2) reversed that portion of the Referee's order which directed the employer to pay claimant's scheduled permanent disability award at a rate of $305 per degree. Submitting a proposed stipulation which purports to resolve the "rate of scheduled permanent disability" issue, the parties have jointly requested reconsideration of our July 22, 1992 order. Inasmuch as our order has become final by operation of law, the motion for reconsideration is denied for lack of jurisdiction.

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

Here, copies of our Order on Review were mailed to all parties to the proceeding on July 22, 1992. Thus, we retained jurisdiction to alter our order through August 21, 1992. ORS 656.295(8). The parties' joint motion for reconsideration is dated August 19, 1992. Nevertheless, the motion, as well as the parties' proposed stipulation, was not received by the Board until August 24, 1992. Unfortunately, by that time, our authority to modify our July 22, 1992 order, as well as to consider the parties' stipulation, had expired.

Although the Board is under no obligation to reconsider its prior orders, we attempt to respond to motions for reconsideration as expeditiously as is possible. Connie A. Martin, 42 Van Natta 495, 853 (1990). However, despite the Board's efforts to rapidly respond to motions for reconsideration, the ultimate responsibility for preserving a party's appeal rights rests with each party. Id.

In conclusion, since our July 22, 1992 order has neither been appealed, abated, "stayed," nor republished, it has become final by operation of law. Consequently, we lack authority to consider the parties' motion for reconsideration and their proposed stipulation.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD L. ZIEMER, Claimant
WCB Case No. 91-00712
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Knapp's order that: (1) found that res judicata precluded an award of temporary total disability benefits; (2) declined to assess a penalty for the SAIF Corporation's allegedly unreasonable delay in authorizing surgery; and (3) assessed an attorney fee of $250 for SAIF's unreasonable delay in authorizing surgery. In his brief, claimant also contends that the Referee erred in refusing to reopen the record for the admission of a post-hearing operative report. We treat claimant's contention as a motion for remand. On review, the issues are res judicata, temporary total disability, penalties and attorney fees, and remand.

We deny the motion for remand and affirm and adopt the Referee's order with the following supplementation.

Res Judicata

Res judicata, or "preclusion by former adjudication," precludes relitigation of claims and issues that were previously adjudicated. Drews v. EBI Companies, 310 Or 134, 139 (1990); North Clackamas School Dist. v. White, 305 Or 48, 50, on recon 305 Or 468 (1988). Under the "claim preclusion" branch of res judicata, if a claim is litigated to a 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 (1982). 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).

By letter dated August 30, 1988, the insurer denied low back surgery. (Ex. 2). Claimant requested a hearing, which was convened before Referee Quillinan in January 1989. At that hearing, claimant's attorney expressly agreed that the issues included "a denial of aggravation," as well as the denial of back surgery. (Ex. 3-5). Following the hearing, Referee Quillinan issued her order which: (1) upheld the denial of back surgery on the basis that it was not reasonable and necessary; and (2) upheld the denial of aggravation on the basis that there had been no worsening of claimant's condition. (Ex. 4-4). Claimant requested Board review of the order, arguing that he had established that his low back condition had worsened requiring surgery. (Ex. 5).

The Board issued its Order on Review on October 31, 1990. In the first paragraph of the order, the Board noted that claimant had requested review of that portion of Referee Quillinan's order that upheld SAIF's denial of back surgery. On the merits, the Board found that the back surgery was reasonable and necessary and, therefore, set aside SAIF's August 30, 1988 denial of surgery. The Board did not address the aggravation issue, but instead, affirmed the remainder of the Referee's order. (Ex. 9). The Board's order was not appealed and became final.

We find that the parties litigated the aggravation claim to a final judgment. Claimant raised the "denial of aggravation" as an issue at hearing. The Referee found the claim not to be compensable and upheld the denial. That decision was affirmed by Board order, which became a final judgment. Additionally, we do not find that claimant's condition had changed prior to the expiration of his aggravation rights on August 10, 1989, so as to have created a new set of operative facts that previously could not have been litigated. See Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560, 563 (1989). Accordingly, claimant is precluded from reasserting the aggravation claim. See Carr, supra; Million, supra. Inasmuch as claimant's entitlement to temporary disability benefits rests on establishing an aggravation, see ORS 656.273(1), we conclude that the Referee properly declined to reopen claimant's claim for temporary disability benefits.

Claimant's entitlement to temporary disability benefits following the expiration of his aggravation rights is a matter within the Board's exclusive "own motion" jurisdiction. See

ORS 656.278(1)(a); Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). We note that, by Own Motion Order dated September 20, 1991, the Board reopened claimant's claim for the payment of temporary disability benefits beginning the date of surgery in May 1991. (Own Motion No. 91-0382M). By Own Motion Order issued this date, we have affirmed SAIF's March 13, 1992 closure of that "own motion" reopening.

Remand

Claimant contends that the Referee erred in refusing to admit a post-hearing report by Dr. Nash, which includes findings from the May 1991 surgery and states that claimant was totally disabled since 1986. Claimant requests that we admit the report for consideration.

Here, given our conclusion that claimant's aggravation claim is precluded by res judicata, the surgical findings and the onset of claimant's disability would have no affect on the outcome of this case. Accordingly, we deny claimant's motion.

Penalties and Attorney Fees

Claimant contends that the Referee erred in declining to assess a penalty for SAIF's allegedly unreasonable delay in authorizing the low back surgery pursuant to the Board's October 31, 1990 Order on Review. We disagree.

By the October 31, 1990 order, the Board set aside SAIF's denial of back surgery. (Ex. 9-3). Despite requests by claimant in December 1990, SAIF did not authorize the surgery until shortly before the hearing in this matter on May 16, 1991, resulting in a delay of more than six months. SAIF offers no reasonable explanation for the delay; therefore, we find its delay to be unreasonable. See Lester v. Weyerhaeuser,, 70 Or App 307, 312 (1984). However, claimant did not actually undergo surgery until May 20, 1991. Thus, there were no amounts of compensation due and owing at the time of SAIF's delay. Absent amounts of compensation "then due," we are not authorized to assess a penalty. ORS 656.262(10)(a).

Nevertheless, an attorney fee may be assessed under ORS 656.382(1) for SAIF's unreasonable resistance to the payment of compensation. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that the Referee's attorney fee award of $250 is reasonable. In reaching this conclusion, we have particularly considered the time devoted to the issue, the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 24, 1991, as republished on August 9, 1991, is affirmed.

Board member Hooton specially concurring.

Claimant argues that we should establish an aggravation effective from the date that the surgery was denied. The basis for his contention is that had the insurer authorized surgery at that time, he would have had a valid aggravation claim upon admission to the hospital for the surgical procedure. Because the surgery was authorized following litigation, the Order on Review finding the surgical procedure compensable should be construed to place the parties in the same position they would have been in had the claim originally been accepted.

Claimant's argument is emotionally and intellectually attractive. In addition to the arguments proposed by claimant, I would note that such an order would prevent employers from denying surgery requests solely to allow the running of the aggravation period as a means of avoiding the payment of additional permanent disability benefits. However, I have not been able to establish any method under the statute to reach that result. Therefore, I agree that the resolution provided in the majority opinion is legally appropriate.

In the Matter of the Compensation of
SHARON L. CLARK, Claimant
WCB Case Nos. 92-04808, 92,04602, 91-14751, 92-01833 & 92-04601
INTERIM ORDER OF DISMISSAL
Nancy F.A. Chapman, Claimant Attorney
Janice M. Pilkenton, Defense Attorney
Davis & Bostwick, Defense Attorneys
David O. Horne, Defense Attorney

Claimant requested review of Referee Podnar's order that: (1) upheld EBI Companies' denials of claimant's bilateral knee condition and left knee surgery; (2) upheld EBI's "de facto" denial of claimant's weight loss and work hardening programs; (3) declined to assess penalties and attorney fees for allegedly unreasonable claim processing; (4) upheld Safeco Insurance's denials of claimant's bilateral knee condition and left knee surgery; and (5) upheld Wausau Insurance's denial of claimant's bilateral knee condition and left knee surgery. Claimant and EBI have submitted a proposed "Disputed Claim Settlement," which is designed to resolve all issues raised or raisable in this matter between them. Specifically, claimant agrees that EBI's denials "shall be affirmed and remain in full force and effect." Furthermore, claimant agrees to the dismissal with prejudice of her request for Board review insofar as it pertains to EBI.

We have approved the parties' agreement, thereby fully and finally resolving all issues raised or raisable between claimant and EBI. Thus, those issues will not be further addressed on review. Nevertheless, in approving this settlement, we wish to emphasize that claimant is accepting the possibility that she will not receive compensation from EBI if, after conducting our review of the Referee's order, we find that EBI is responsible for claimant's claims. See E.C.D., Inc. v. Snider, 105 Or App 416 (1991); Jack Spinks, 43 Van Natta 1181 (1991).

Inasmuch as claimant's request for review concerning Safeco and Wausau remains pending, we retain jurisdiction over this case. Accordingly, this order shall be interim, pending our review of the remaining issues, and shall eventually be incorporated into our final, appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT G. FULS, Claimant
WCB Case Nos. 91-01005 & 90-17213
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Steve Cotton (Saif), Defense Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Hooton and Brazeau.

The SAIF Corporation requests review of that portion of Referee Quillinan's order that set aside its "de facto" denial of claimant's claim for a psychological condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the "FINDINGS OF FACT" section of the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Because claimant filed his hearing request after May 1, 1990, and the hearing was convened after July 1, 1990, this matter is properly analyzed under the Workers' Compensation Law, as amended effective July 1, 1990. See Or Laws 1990 (Special Session), ch 2, § 54; Ida M. Walker, 43 Van Natta 1402 (1991).

The Referee concluded that claimant established the compensability of his psychological condition, based on the finding that the February 1990 work incident was a material contributing cause of the condition. In applying the "material contributing cause" standard, the Referee rejected SAIF's argument that the psychological condition must be analyzed as an occupational disease under ORS 656.802. The Referee reasoned, instead, that the appropriate standard is the same as that required to prove the compensability of a psychological condition following an industrial injury. On review, SAIF reasserts its argument that claimant's claim must be analyzed as an occupational disease under ORS 656.802. We agree.

We note that claimant's psychological condition is not alleged to be a consequence of an industrial injury. Rather, it is alleged to have resulted from a February 1990 work incident in which a customer greeted him by grabbing his arms from behind and shaking him. (Ex. 92A; Tr. 15-16). Thus, we conclude that claimant is seeking to establish that his psychological condition is an independently compensable result of on-the-job stress.

Subsequent to the Referee's order, the Court of Appeals held in SAIF v. Hukari, 113 Or App 475 (1992), that "any claim that a condition is independently compensable because it was caused by on-the-job stress, regardless of the suddenness of onset or the unexpected nature of the condition, and regardless of whether the condition is mental or physical, must be treated as an occupational disease claim under ORS 656.802." See also Jerry B. Mathel, 44 Van Natta 1113 (1992), on recon 44 Van Natta 1532 (concluded that Hukari holding is equally applicable to current ORS 656.802, as amended effective July 1, 1990). Therefore, in order to prevail in this case, claimant must satisfy the requirements of establishing a compensable mental disorder under ORS 656.802(2) and (3).

Among other requirements, claimant must prove that the "employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation." See ORS 656.802(3)(b). The Court of Appeals ruled in SAIF v. Campbell, 113 Or App 93 (1992), that the Board is authorized to develop the legal standard of what "conditions [are] generally inherent in every working situation" on a case-by-case basis, and that the standard need not be established by evidence in the record.

On February 23, 1990, claimant was working as a gas station attendant for SAIF's insured. While he stood at the cash register processing a credit card purchase, a customer walked up behind him and greeted him by grasping his upper arms and briefly shaking him. (Tr. 4, 15-16). Claimant immediately lost control of his legs and collapsed to the floor. (Tr. 4-5). He was able to stand up and walk to a chair, but then he felt completely paralyzed from the neck down. (Ex. 90). He was taken to the hospital emergency room strapped to a back board with a cervical collar. (Id.) Approximately four hours later, claimant felt severe pain from his neck to his feet. (Tr. 5). He was diagnosed with conversion hysteria. (Exs. 90, 94).

We are not persuaded that the employment conditions producing claimant's conversion hysteria are conditions other than those generally inherent in every working situation. Virtually every working situation involves some degree of interaction with co-employees and/or the public, whether it be verbal exchanges or physical contact. While we acknowledge that not all types of interaction are generally inherent in every working situation, we recognize that those types that are inherent in every working situation vary with the individuals involved. The "bear hug" which claimant received (see Ex. 98-6) is certainly a more physical type of interaction; however, we are not prepared to find that it is outside the range of behavior that occurs in every working situation.

For that reason, we do not find that claimant has sustained his burden of proving all of the elements of an occupational disease claim for a mental disorder under ORS 656.802(3). SAIF's denial of claimant's conversion reaction is upheld.

ORDER

The Referee's order dated July 31, 1991 is reversed in part and affirmed in part. That portion of the order that set aside the SAIF Corporation's "de facto" denial of claimant's psychological condition is reversed. SAIF's denial is reinstated and upheld. The Referee's attorney fee award for prevailing over the denial is also reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
ZODELLE L. HALBERG, Claimant
WCB Case No. 90-22039
ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

Claimant requests reconsideration of our August 19, 1992 order which affirmed a Referee's order that upheld the insurer's denial of claimant's proposed knee surgery request. Asserting that "this claim was resolved in its entirety by way of a Disputed Claim Settlement," claimant asks that we withdraw our order.

In light of these circumstances, we withdraw our August 19, 1992 order. The insurer is granted an opportunity to respond. To be considered, the insurer's response must be filed within 14 days from the date of this order. During this time, the parties are further requested to provide a copy of the Disputed Claim Settlement (DCS) which, without Board approval, purportedly resolved this dispute. See OAR 438-09-015(5). Upon completion of the aforementioned 14 day period and receipt of a copy of the DCS, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
KIM LAKODUK, Claimant
WCB Case No. TP-92006
THIRD PARTY ORDER OF DISMISSAL
A. Michael Adler, Claimant Attorney
David O. Horne, Defense Attorney

The paying agency petitioned the Board for relief under the third party statutes. ORS 656.576 et seq. The dispute apparently pertained to claimant's refusal to acknowledge the paying agency's lien against a purported third party settlement. On September 8, 1992, we approved the parties' Claim Disposition Agreement (CDA), in which claimant agreed to fully release her rights to all her past, present and future benefits, except medical services, for her compensable injury. WCB Case No. C2-01532. Pursuant to the CDA, claimant also allowed the paying agency to claim $5,000 of a purported third party settlement as reimbursement for a portion of its alleged lien. In acknowledging the $5,000 allowance, the parties agreed that claimant was not admitting the paying agency's entitlement to a lien nor was the paying agency recognizing full satisfaction of its purported lien.

In light of the approved CDA, it follows that no third party dispute remains pending for Board resolution. Accordingly, the petition for third party relief is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
RANDI E. MORRIS, Claimant
WCB Case No. 91-10914
ORDER ON REVIEW
Howser & Munsell, Claimant Attorneys
Ronald K. Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Mongrain's order that upheld the SAIF Corporation's denial of claimant's back 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

The Referee found that claimant failed to prove the compensability of her claim based on his conclusion that the medical opinion did not "link any objective findings to the described history [of injury]."

After a table dropped on April 8, 1991, striking claimant's left shoulder blade, she was examined by Dr. Thomas, D.O., on April 11, 1991. Dr. Thomas found "tenderness to palpation with some acute tissue texture abnormality and deep muscle tension noted in the paravertebral intrathoracic region bilaterally." (Ex. 3-1). Dr. Thomas diagnosed "thoracic paravertebral muscle contusion" and recommended that she continue her physical therapy but "include treatment for the newly injured midthoracic region as well." (Id. at 2). Dr. Thomas later explained that the "terms acute and chronic do correspond to how long the abnormality has been present. A more recent musculoskeletal injury would tend to have the acute findings whereas one that happened sometime ago and the acute phases had resolved becomes chronic[.]" (Ex. 6).

When claimant saw her treating physician, Dr. Dunn, neurological surgeon, he noted that claimant "had good continuous improvement until on April 8 she had a table dropped on her back." (Ex. 2).

We find that the medical record is sufficient to prove compensability. First, contrary to SAIF's assertion, we find that claimant established her claim with medical evidence supported by objective findings. Dr. Thomas found "tenderness to palpation with some acute tissue texture abnormality and deep muscle tension," diagnosed "thoracic paravertebral muscle contusion," and recommended physical therapy for the injured area. Such findings satisfy ORS 656.005(7)(a). See Georgia Pacific Corp. v. Ferrer, 114 Or App 471 (1992); Suzanne Robertson, 43 Van Natta 1505 (1991). Furthermore, there were no medical reports disputing those objective findings.

We further conclude that claimant proved medical causation. Although the medical reports do not explicitly attribute claimant's symptoms to an injurious event, when read in their entire context, it is clear that the cause of claimant's need for treatment is the work incident. For instance, Dr. Thomas' report recounts claimant's history regarding the table dropping on her shoulder, as well as her subsequent symptoms. Dr. Thomas then notes "tenderness" and "some acute tissue texture" and renders a diagnosis. Dr. Dunn also indicates that claimant's symptoms are due to the work injury when he reported that claimant had "good continuous improvement until on April 8 she had a table dropped on her back."

Finally, we note that the record contains no evidence indicating that claimant's symptoms were attributable to her 1987 injury. On the contrary, Dr. Dunn noted two months prior to the work incident that claimant was "virtually asymptomatic." (Ex. 2). Dr. Thomas also was aware that claimant had been diagnosed with a "cervical degenerative disc disease at C5-6" and a "myofascial syndrome" and yet in no way attributed claimant's symptoms to these prior conditions.

Accordingly, we conclude that, in the context of the entire record, claimant proved that the work incident was a material contributing cause of her need for medical services. See Mark N. Wiedle, 43 Van Natta 855 (1991).

Because claimant finally prevailed on review, claimant's attorney is entitled to an assessed fee for services at hearing and on review. 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 $3,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellant's briefs), the complexity of the issue, and the value to claimant of the interest involved.

ORDER

The Referee's order dated December 12, 1991 is reversed. The SAIF Corporation's denial is reversed and set aside. The claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed fee of $3,000, to be paid by the SAIF Corporation.

September 11, 1992 Cite as 44 Van Natta 1775 (1992)

In the Matter of the Compensation of
CHUCK NORTHCUTT, Claimant
WCB Case No. 89-14670
ORDER ON REMAND
Malagon, et al., Claimant Attorneys
David L. Runner (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Our prior order reversed the Referee's order that awarded an assessed attorney fee for services regarding the SAIF Corporation's pre-hearing rescission of its denial of claimant's back strain and ruptured disc claim. Chuck Northcutt, 43 Van Natta 35 (1991). The court has reversed and remanded our order. Northcutt v. BJ's Ice Cream Parlor, 113 Or App 748 (1992).

FINDINGS OF FACT

We republish the "Findings of Fact" contained in our prior order with the following supplementation.

Claimant sustained an injury in Idaho several years before filing the claim in this case. As a result, prior to the scheduled hearing, claimant's attorney obtained various reports from Washington and Idaho regarding the prior out-of-state injury. Claimant's attorney also solicited reports from claimant's treating Oregon physician and consulted claimant's attorney in Idaho. Finally, claimant's attorney filed the request for hearing. Claimant's attorney was instrumental in obtaining compensation for claimant without a hearing.

CONCLUSIONS OF LAW AND OPINION

Based on a prior administrative rule allowing for the assessment of a reasonable attorney fee if an attorney is instrumental in obtaining compensation for the claimant without a hearing, the Referee awarded claimant's attorney an assessed fee of $3,037.50.

On review, the Board reversed the attorney fee award. Relying on its order in Duane L. Jones, 42 Van Natta 875 (1990), the Board found that, because the matter was resolved before hearing, claimant's attorney was not entitled to an assessed fee. Chuck Northcutt, supra.

On appeal, the Court of Appeals reversed and remanded based on its decision in Jones v. OSCI, 108 Or App 230 (1991). Northcutt v. BJ's Ice Cream Parlor, supra. Jones held that, as provided by the

1991 amendment to ORS 656.386(1), 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."

Considering the solicitation of reports by claimant's attorney, the issue of contribution by the prior out-of-state injury, the fact that SAIF did not issue its pre-hearing rescission until shortly before the scheduled hearing, the nature of claimant's condition, and the filing by claimant's attorney of the request for hearing, we conclude that claimant's counsel was instrumental in obtaining compensation. Therefore, claimant is entitled to a carrier-paid attorney fee. ORS 656.386(1).

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 fee concerning the pre-hearing rescission of SAIF's denial is $3,037.50 as awarded by the Referee to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's attorney's trial memo and affidavit), the value of interest involved, and the risk that claimant's attorney's efforts may go uncompensated.

Accordingly, on reconsideration, the Referee's order is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
FARRELL D. PELLETIER, Claimant
WCB Case No. 91-12701
ORDER ON REVIEW
Vance D. Day, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Nichols' order that: (1) dismissed claimant's request for hearing; (2) set aside an Order on Reconsideration as invalidly issued; and (3) found that jurisdiction over this matter remains with the Appellate Review Unit of the Workers' Compensation Division (WCD) in the Department of Insurance and Finance (Department). On review, the issue is the validity of the WCD's Order on Reconsideration. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact." In addition, we add the following findings.

In her Request for Reconsideration, claimant indicated that she disagreed with the impairment findings made by her attending physician at the time of claim closure.

The Order on Reconsideration issued without consideration of a medical arbiter's report.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, the self-insured employer moves to strike portions of claimant's appellant's brief. First, it objects to the reference on page one to an "Interim Order of Remand," noting that no such order issued. The employer is correct. It appears that because the Referee recited that the record is incomplete and found the Order on Reconsideration to be invalid, claimant has mislabeled the order as one on remand. We have the proper Opinion and Order before us for review. To the extent that claimant's brief refers to the order as an Interim Order on Remand, we "correct" claimant's brief. Moreover, had the Referee issued an Interim Order of Remand, this Board would have the authority to consider matters raised by claimant's request for Board review of an appealable final order. See Mickey L. Platz, 44 Van Natta 16 (1992).

The employer also objects to the reference on page three to a communication from the Appellate Review Unit. We agree that the communication has not been made a part of the record, and do not consider it on review. We now turn to the merits of the claim.

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

The Referee reasoned that, because the Director did not comply with ORS 656.268(7) which requires the appointment of a medical arbiter, the Order on Reconsideration was invalid. We agree.

Subsequent to the Referee's order, we concluded that 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 an Order on Reconsideration, and one of the parties objects to the order issued, the Order on Reconsideration is invalid. Olga I. Soto, 44 Van Natta 697 (1992), recon denied, 44 Van Natta 1609 (1992).

On review, claimant explains that she "agrees with the Referee's legal reasoning and conclusions stated in the Opinion and Order," and has requested review by the Board only "to protect her rights." She requests that the Referee's order be affirmed in its entirety.

The employer likewise responds that the Referee's order should be affirmed. However, the employer miscasts the Referee's order as "simply dismissing claimant's Request for Hearing." However, the order also set aside the Appellate Review Unit's Order on Reconsideration as invalidly issued, and found that jurisdiction over this matter remains with the Appellate Review Unit.

Accordingly, we agree with the Referee that, because claimant disagreed with the impairment findings of her treating physician used in the rating of her disability award, the Director was required to appoint an arbiter. Consequently, because the Director issued his order prior to receiving and considering findings from a medical arbiter, the Order on Reconsideration is invalid and jurisdiction over the dispute remains 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. Olga I. Soto, supra; Mickey L. Platz, 44 Van Natta 1056 (1992).

ORDER

The Referee's order dated December 19, 1991 is affirmed.

In the Matter of the Compensation of
GEORGE SANDOR, Claimant
WCB Case Nos. 91-04053 & 90-19313
ORDER ON REVIEW
Flaxel, Todd, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Spangler's order that: (1) upheld KRI Construction Incorporated's denial of claimant's aggravation claim for a low back condition; (2) upheld Georgia-Pacific Corporation's denial of claimant's "new injury" claim for the same condition; (3) awarded claimant interim compensation from October 29, 1990 to June 13, 1991; and (4) assessed a penalty for Georgia-Pacific's allegedly unreasonable denial and failure 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.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had failed to establish a compensable claim against either KRI Construction or Georgia-Pacific and, accordingly, upheld both denials. He based his decision on claimant's lack of credibility and the lack of persuasive medical evidence to support the claims. The Referee, however, ordered Georgia-Pacific to pay interim compensation for the period from October 29, 1990, the date it first had knowledge of the claim, through June 13, 1991, the date of the hearing. The Referee also determined that Georgia-Pacific's failure to pay interim compensation was unreasonable and assessed a penalty.

After our review, we agree that claimant has failed to establish the compensability of either claim. Accordingly, we affirm and adopt that portion of the Referee's order.

Georgia-Pacific contends that the Referee erred in concluding that claimant is entitled to interim compensation. It contends that there was no duty to commence payment of such benefits, because there is no evidence that claimant ever left work due to his alleged occupational exposure.

"Interim compensation" is a term coined by the Supreme Court in Jones v. Emanuel Hospital, 280 Or 147 (1977), to refer to temporary total disability benefits an insurer or self-insured employer must pay an injured worker during the processing of a claim for compensation. ORS 656.262(4) requires a carrier to commence payments of such compensation within 14 days of notice of the claim, unless the claim has been denied. However, a claimant is entitled to interim compensation only if he has "left work" as that phrase is used in ORS 656.210(3). Bono v. SAIF, 298 Or 405, 410 (1984).

In this case, we agree with the Referee that Georgia-Pacific first had knowledge of the claim on October 29, 1990. We conclude, however, that there was no evidence of disability sufficient to trigger a duty to pay interim compensation. In July 1990, Dr. Bert, claimant's treating physician, noted that claimant was limited to light duty work and that his work at Georgia-Pacific was a material contributing cause for his need for treatment. However, Dr. Bert expressly based his opinion on claimant's history that he had worked as a surveyor in May 1990, when, in fact, claimant had been laid off for reasons unrelated to his back condition in April 1990. Moreover, Dr. Bert concluded that the major contributing cause of claimant's current low back condition was an injury sustained in 1985.

After our review, we conclude that Dr. Bert's report is insufficient to establish that claimant had "left work" due to his work exposure at Georgia-Pacific. Consequently, there was no obligation on the part of Georgia-Pacific to commence the payment of interim compensation, regardless of the fact that the employer did not formally deny the claim within 14 days after notice. Because claimant was not entitled to receive interim compensation, it follows that Georgia-Pacific did not unreasonably delay or resist the payment of compensation. Accordingly, we also reverse that portion of the Referee's order that assessed a penalty under ORS 656.262(10).

ORDER

The Referee's order dated September 19, 1991 is affirmed in part and reversed in part. Those portions that ordered Georgia-Pacific Corporation to pay claimant interim compensation and assessed a penalty for its failure to pay such compensation are reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
KENNETH L. THOMPSON, Claimant
WCB Case No. 91-07007
ORDER OF ABATEMENT
Black, et al., Claimant Attorneys
David Schieber (Saif), Defense Attorney

Claimant requests reconsideration of our August 20, 1992 order, which reinstated a Notice of Closure award of 26 percent scheduled permanent disability for loss of use or function of the left thumb, whereas a Referee had awarded 23 percent scheduled permanent disability for loss of use or function of

the left forearm. Contending that he is entitled to an award for a loss of grip strength and that we neglected to adequately explain our disagreement with the Referee's conclusions, claimant seeks further consideration and an increased scheduled permanent disability award.

We withdraw our August 20, 1992 order to consider claimant's motion. The SAIF Corporation is granted an opportunity to respond. To be considered, SAIF's response must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

September 11, 1992 Cite as 44 Van Natta 1779 (1992)

In the Matter of the Compensation of
RUAL E. TIGNER, Claimant
WCB Case Nos. 88-00682, 87-14482 & 87-15942
ORDER ON REMAND
Bennett & Hartman, Claimant Attorneys
Davis & Bostwick, Defense Attorneys
Roberts, et al., Defense Attorneys
Rankin, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Multnomah County School District v. Tigner, 113 Or App 405 (1992). The court has held that claimant was not entitled to a carrier-paid attorney fee under ORS 656.386(1) for services rendered at the hearing regarding responsibility for claimant's stress condition. Consequently, the court reversed that portion of our order, Rual E. Tigner, 42 Van Natta 2643 (1990), which awarded claimant a carrier-paid attorney fee to be paid by Liberty Northwest. In addition, the court has remanded.

Inasmuch as the court has concluded that claimant was not entitled to an attorney fee award under ORS 656.386(1) for services at hearing, we reverse that portion of the Referee's order that granted claimant a $3,100 carrier-paid attorney fee.

IT IS SO ORDERED.

September 11, 1992 Cite as 44 Van Natta 1779 (1992)

In the Matter of the Compensation of
HAROLD D. WOLFORD, Claimant
WCB Case No. 91-11300
ORDER ON REVIEW
Ralph M. Yenne, Claimant Attorney
Alan Ludwick (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of that portion of Referee Howell's order that denied its motion to dismiss claimant's allegedly untimely hearing request. On review, SAIF contends that claimant has not established "good cause" for his late appeal of SAIF's denial. We agree and reverse.

FINDINGS OF FACT

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

SAIF's denial letter was unambiguous and included appeal rights.

Claimant's hearing request was not filed within 60 days from the date he had actual notice of SAIF's April 9, 1991 denial letter.

At hearing, SAIF moved for dismissal of claimant's hearing request as untimely. The Referee deferred a ruling on SAIF's motion until he could develop a hearing record on all issues.

Claimant has not shown good cause for his failure to file a timely request for hearing.

CONCLUSIONS OF LAW AND OPINION

Finding that claimant's erroneous interpretation of SAIF's denial letter constituted "mistake" as that term is used in ORCP 71B, the Referee concluded that claimant has established "good cause" for his failure to request a hearing within 60 days. On review, SAIF argues that claimant's "mistaken" interpretation of its denial letter does not constitute "a legal mistake sufficient" to establish good cause. We agree.

A request for a hearing must be filed no later than the 60th day after claimant is notified of a denial of a claim. ORS 656.319(1)(a). A hearing request that is filed after 60 days, but within 180 days of a denial, is timely if claimant establishes good cause for the late filing. ORS 656.391(1)(b).

The test for determining whether "good cause" exists has been equated with the standard of "mistake, inadvertence, surprise or excusable neglect" recognized under ORCP 71(B)(1) and former ORS 18.1160. Anderson v. Publishers Paper Co., 78 Or App 513, 517, rev den 301 Or 666 (9186). Lack of diligence does not constitute good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985). Claimant has the burden of proving good cause. Id.

Claimant contends that he has established good cause for not filing the hearing request within 60 days. Claimant relies primarily on the fact that SAIF included a check for interim compensation at the same time he received its denial letter. Thus, he testified, he assumed SAIF was paying him for his time off work and was going to pay his medical bills up until the time he returned to work. He further explained that because he had been released to go back to work and was feeling better, he did not think that there was anything to appeal.

The language of SAIF's denial is not ambiguous. Furthermore, claimant was properly informed of his appeal rights. We have previously found that receipt of interim compensation at the same time a denial is issued does not constitute good cause for not requesting a hearing from a denial. See Bonnie J. Santangelo, 42 Van Natta 1979 (1990); Robert E. Derby, 41 Van Natta 405 (1989). Claimant's decision not to file a request for hearing sooner from SAIF's denial was not mistake, inadvertence, surprise or excusable neglect under ORCP 71B. Moreover, because his condition was better at the time, claimant decided not to appeal the denial. Neither does this lack of diligence constitute "good cause." See Cogswell v. SAIF, supra.

Because we conclude that claimant has failed to establish good cause for his untimely request for hearing, we do not consider the merits of SAIF's denial nor the penalty and attorney fees issues.

ORDER

The Referee's order dated November 26, 1991 is reversed. Claimant's request for hearing is dismissed.

In the Matter of the Compensation of
JONNA COLUMBELL, Claimant
WCB Case No. 91-10363
ORDER ON REVIEW
Bryant Emerson, Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Myers' order that upheld the insurer's denial of her occupational disease claim for a bilateral hip condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except that the last sentence is replaced as follows:

"Claimant's work activities for the employer were the major contributing cause of her current disability and/or need for treatment for bilateral hip overuse and popping hip syndromes."

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant proved that her work caused a mere worsening of symptoms in a hip condition which preexisted her work exposure with the insured. The Referee then concluded that claimant failed to carry her burden, under ORS 656.802(2), of proving that her work activities or exposures were the major contributing cause of a worsening of that condition. We disagree.

Under ORS 656.802(2), "The worker must prove that employment conditions were the major contributing cause of the disease or its worsening. Existence of the disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings."

We note at the outset that claimant sought prior treatment for bilateral hip pain once, on November 28, 1983. (Ex. 1). Her then-current problem was diagnosed as "probable postural strain, low back and both hips; probably anxiety-related." (Id). There is no evidence that claimant's 1983 postural strain had lasting consequences or that it contributes to her current hip complaints. The only evidence suggesting a preexisting hip disease or condition is Dr. Utterback's opinion that claimant's current hip problem has a genetic basis. (See Ex. 9-2). As discussed below, Dr. Bird, claimant's treating physician, rejected Dr. Utterback's opinion, and we find no basis in this record not to defer to Dr. Bird, as claimant's treating physician. In addition, although claimant's slight build has been identified as limiting her ability to perform heavy work, it is not a preexisting disease or condition. Under these circumstances, we are not persuaded that claimant had a preexisting hip "disease," within the meaning of the ORS 656.802(2). Accordingly, claimant need only prove that her work activities for the insured were the major contributing cause of her current bilateral hip disease(s), diagnosed as overuse and/or popping hip syndromes. See ORS 656.802.

Claimant sought treatment from Dr. Bird for bilateral hip pain on March 22, 1991. Bird took claimant's history that she had had similar problems in 1983. Claimant also told Bird that she currently worked as a banquet manager which required "quite a bit of heavy set up." She stated that "the more that she does, the more her hips hurt." (Ex. 2-1). Bird diagnosed "probable overuse syndrome with muscle tightness." (Id). He opined that claimant's "work duties contributed significantly to her symptoms." (Id). Bird also stated that claimant has "popping hip syndrome," involving her iliopsoas tendon and fascia lata and that claimant's very slight build would not allow her to do "significantly heavy work over a long period." (Ex. 3). Bird later explained that claimant's popping hips were probably related to muscle tightness and that:

> "[her] problems stem "primarily from 'overuse syndrome' of the legs. This has to do with lifting and carrying by the patient's history. Since she had similar problems in the past, one could consider this an exacerbation of an old condition, but in my opinion it is related to the current work she was doing as a banquet manager. I do not

think this is congenital in nature. I do not think anything has structurally changed in [claimant's] hips, but her symptoms are more prominent because of muscle tightness." (Ex. 6, emphasis added).

Dr. Utterback, who examined claimant once, on September 4, 1991, provides the only other expert opinion concerning causation. Utterback agreed with Bird's diagnosis of bilateral snapping hip syndrome. However, he opined that:

"this syndrome has genetic basis and that the etiology of the snapping hip syndrome is neither overuse syndrome, nor is it secondary to any type of injury. Rather, the basic underlying condition simply makes it very easy to 'overuse' the area, and cause symptoms. [Claimant] simply has a condition that will not allow her to do much in the way of lifting, carrying or walking without becoming symptomatic. This does not mean that becoming symptomatic causes any change in the basic underlying process[.]" (Ex. 9-2, emphasis added).

By letter dated September 20, 1991, Bird disagreed with that portion of Utterback's opinion which related claimant's popping hip syndrome to her genetic make-up. (Ex. 9B; see Ex. 11). In his letter, he suggested the possibility that claimant's problem "may indeed be developmental and not related to injury or use of the leg," but he rejected Dr. Utterback's opinion that the problem was hereditary. (Id). In subsequent correspondence, he reiterated his opinion that heavy lifting and other work activities were the major cause of claimant's current pain and need for treatment. (Ex. 11).[1]

Dr. Bird had and analyzed an accurate history, considered and ruled out causes other than work activities and concluded that claimant suffered from overuse syndrome, the major contributing cause of which was her work activities. We find no reason not to defer to Dr. Bird's well reasoned opinion. See Weiland v. SAIF, 64 Or App 810 (1983). We therefore conclude that claimant has carried her burden of proving that she has an occupational disease and the existence of that disease is established by medical evidence supported by objective findings. (See Ex. 2). ORS 656.802(2); see Georgia Pacific Corp. v. Ferrer, 114 or App 471 (1992); Suzanne Robertson, 43 Van Natta 1505 (1991).

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 $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 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 October 29, 1991 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for further processing in accordance with law. For his services at hearing and on review, claimant's counsel is awarded an attorney fee of $3,500, payable by the insurer.

[1] In suggesting the possibility that claimant's problem was "developmental" and not related to overuse of her legs, we understand Dr. Bird's sole purpose was to underscore his fundamental disagreement with Dr. Utterback's opinion that claimant's condition was genetic in origin. We do not find that he had and was expressing doubt about the validity of his own opinion.

In the Matter of the Compensation of
DORTON H. NEWMAN, Claimant
WCB Case No. 91-11646
ORDER ON RECONSIDERATION
Gatti, et al., Claimant Attorneys
David O. Horne, Defense Attorney

Claimant requests reconsideration of that portion of our August 20, 1992 Order on Review that awarded a $1,500 attorney fee for claimant's counsel's services at hearing and on review. Specifically, claimant requests that we reconsider the amount of the attorney fee awarded in light of the amount of work performed by counsel and the complexity of the issue.

After conducting our reconsideration of the evidence in the record, noting that claimant's counsel did not submit a statement of services, we conclude that $3,000 is a reasonable fee for counsel's services at hearing and on review concerning the compensability issue. 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 to claimant of the interest involved.

Our August 20, 1992 order is withdrawn. On reconsideration, we adhere to and republish our August 20, 1992 order as supplemented and modified herein. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
VINCE W. PROWELL, Claimant
WCB Case No. 91-06520
ORDER ON REVIEW
Smith & Smith, Claimant Attorneys
Bullard, et al., Defense Attorneys

Reviewed by Board Members Moller and Hooton.

The self-insured employer requests review of Referee Brown's order that set aside its "back-up" denial of claimant's claim for his right thrombophlebitis condition. Alternatively, the employer contends that the Referee's attorney fee award of $2,800 was excessive. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact with the exception of Findings #6 and #7.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that the employer failed to carry its burden of proof regarding the compensability of claimant's thrombosis condition. We agree.

Pursuant to amended ORS 656.262(6), a carrier may issue a "back-up" denial at any time up to two years from the date of claim acceptance. Within that two-year period, a carrier need not prove fraud, misrepresentation or other illegal activity in support of its "back-up" denial. Anthony G. Ford, 44 Van Natta 240 (1992). Instead, the carrier must establish by clear and convincing evidence obtained after the acceptance that the claim is not compensable. Sharon J. True, 44 Van Natta 261 (1992).

Here, the employer's "back-up" denial was issued within two years of the date that it accepted claimant's low back injury claim. Because claimant requested a hearing from the employer's denial, the

employer is required to prove by clear and convincing evidence that the claim is not compensable. ORS 656.262(6). Therefore, the employer can prevail if it proves by clear and convincing evidence that claimant did not experience a compensable thrombophlebitis condition. 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).

We first address the employer's contention that inconsistencies in claimant's testimony establish that he is not credible. We note that the Referee found that claimant did credibly testify regarding the circumstances of his injury. Although we agree with the Referee's conclusion that there are some inconsistencies in the record, we do not find those inconsistencies sufficient to convince us that claimant is not credible or that the doctors do not have an accurate history of the injury.

The employer next argues that the medical evidence "forcefully" establishes that claimant's leg condition is idiopathic. We disagree.

To carry its burden, the employer relies on the opinion of Dr. Porter, an independent medical examiner. Dr. Porter examined claimant on one occasion and reviewed claimant's medical records. Based on his examination and those records, he stated that he did not "identify any medically probable causal relationship between the incident on December 14, 1990, and the deep venous thrombotic condition." Dr. Porter stated that it is possible "to state with relative certainty what is the cause of venous thrombosis in only a minority of patients." He provided an incomplete list of known causes of venous thrombosis, then opined that claimant's activities as related in the medical records do not constitute a recognized cause of venous thrombosis.

We conclude that Dr. Porter's opinion lacks persuasiveness. Having provided an incomplete list of recognized causes of venous thrombosis, he offers no affirmative explanation for his conclusion that claimant's activities could not be a cause of the condition. Rather, he relies on negative inferences based on the fact that those activities are not a "recognized cause" as well as his statement that in a majority of episodes of venous thrombosis, there is no "fully developed cause and effect relationship to any event." In order for his report to be "free from confusion, fully intelligible and distinct," we need more explanation than is provided.

Moreover, Dr. Merhoff, claimant's treating physician, reviewed Dr. Porter's report and disagreed with Dr. Porter's opinion. Dr. Merhoff stated that the "historical relationship between events on the job and the development of pain and swelling in the extremity which eventually was diagnosed as being a deep venous thrombosis" led him to the conclusion that claimant's work and his condition were related. Dr. Merhoff considered claimant's off-the-job activity and found that it would not have been likely to predispose claimant to the thrombosis condition. Further, Dr. Merhoff noted that claimant had no recognized predisposition to venous thrombosis.

Accordingly, in light of the relative unpersuasiveness of Dr. Porter's opinion, and the contrary opinion of claimant's treating physician, we agree with the Referee's conclusion that the employer has failed to prove by clear and convincing evidence that the claim is not compensable.

Attorney fees

The employer asserts that the Referee's attorney fee award of $2,800 for claimant's counsel's services at hearing is an excessive award. However, the employer has not provided any reasoning to support its assertion that, in this case, the attorney fee award is excessive. After considering the factors set forth in OAR 438-15-010(4) and reviewing the record, we decline to reduce the Referee's attorney fee award.

The employer requested review and we have found that claimant's compensation should not be disallowed or reduced. Accordingly, claimant's counsel is entitled to an assessed attorney fee for services on review. ORS 656.382(2). 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 on Board review concerning the compensability issue is $900. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated December 19, 1991 is affirmed. For services on review concerning the issue of compensability, claimant's counsel is awarded an assessed fee of $900, to be paid by the self-insured employer.

September 14, 1992 Cite as 44 Van Natta 1785 (1992)

In the Matter of the Compensation of
DONNA M. WOLFE, Claimant
WCB Case No. TP-92004
THIRD PARTY ORDER
Olson, et al., Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

The SAIF Corporation has petitioned the Board for resolution of a dispute concerning a purported third party settlement. Specifically, SAIF contends that it is entitled to a share of a settlement between claimant and an alleged third party that was achieved while claimant's injury claim was in a denied status. We hold that SAIF was not a paying agency when the settlement was reached and, therefore, may not share in claimant's recovery.

FINDINGS OF FACT

In September 1988, claimant was injured in a motor vehicle accident with another vehicle. She filed a workers' compensation claim for her injuries with her employer. SAIF, as insurer for her employer, denied the claim. Claimant requested a hearing concerning the denial.

In February 1990, while claimant's hearing request was pending, claimant and the the driver of the other vehicle involved in the accident reached a settlement of claimant's negligence action. Specifically, claimant settled her cause of action for $38,851.77.

Shortly after the settlement, a hearing was convened regarding SAIF's denial. Pursuant to a March 1990 order, a Referee found claimant's injury claim to be compensable. Consequently, SAIF's denial was set aside and SAIF began processing the claim. Thereafter, SAIF sought a portion of claimant's settlement as reimbursement for its actual and future claim costs.

When claimant challenged SAIF's right to share in the settlement proceeds, SAIF petitioned the Board for resolution of this dispute.

CONCLUSIONS OF LAW

On remand from the Supreme Court, the Court of Appeals has reasoned that, when at the time a settlement is reached between an injured worker and a purported third party, 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. SAIF v. Wright, 113 Or App 267 (1992). Under such circumstances, the Court of Appeals has held that 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.

Here, when claimant's settlement was reached her appeal of SAIF's denial was pending before the Hearings Division. Inasmuch as the claim was in denied status, SAIF was not providing benefits. Consequently, in accordance with the Wright holding, SAIF was not a paying agency at the time of claimant's settlement. Inasmuch as SAIF was not a paying agency, it cannot share in claimant's recovery.

Accordingly, we hold that SAIF is not entitled to a share of the settlement proceeds.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT L. PARSONS, Claimant
WCB Case No. 91-06721
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Mills' order that dismissed claimant's request for hearing. On review, the issues are the res judicata effect on this proceeding of a prior Order on Review, extent of scheduled permanent disability, permanent total disability, and rate of scheduled permanent disability.

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

Scheduled Permanent Partial Disability

Assuming without deciding that claimant's request for right arm scheduled permanent disability is not precluded by the prior proceeding, we are not persuaded that he has suffered a permanent loss of use or function of the right arm as a result of his compensable injury. Therefore, he is not entitled to a scheduled permanent disability award for the right arm. Our conclusion is based on the following reasoning.

Claimant contends that he is entitled to such an award for loss of total sensation of his right thumb, right index finger, and right middle finger, former OAR 436-35-110(1)(a); loss of sensation in the entire palm of his right hand, former OAR 436-35-110(1)(e); loss of grip strength in the right forearm due to "anatomical changes (Biceps Tendon Rupture) and damage to nerves (Mild Perpheral Neuropathy), former OAR 436-35-110(3)(a) and (d); and a chronic condition limiting repetitive use of his right arm, former OAR 436-35-010(7). We disagree with each of claimant's contentions.

First, there is no medical evidence proving that claimant has loss of total sensation in any of his digits on the right hand. At best, the medical evidence shows that claimant, in August 1989, reported "subjective diminished sensation in the first three digits of the right hand." (Ex. 50). Such evidence is not sufficient to entitle claimant to ratings under the applicable standards.

With regard to his contention regarding loss of sensation in his palm, claimant relies on a January 1989 report reporting a "total loss of sensation to pinwheel in both the dorsal and volar aspects of the right hand." (Ex. 32-4). Even if we could construe this one statement as entitling claimant to a rating under former OAR 436-35-110(d), we find no evidence that this condition is due to his right arm condition. Therefore, we decline to give claimant a rating on this basis.

Claimant also has no entitlement to impairment for a "bicipital tendon rupture" since this condition related to his shoulder injury rather than the right arm condition. (See Ex. 32-5). There is no medical evidence proving nerve damage or that any alleged nerve damage resulted in loss of grip strength. Finally, although claimant cites to a report stating "grip strength is 44 pounds; on the left, 130 pounds," (Ex. 36-4), there is no evidence that this finding is due to his right arm condition. Therefore, we find that claimant failed to prove an entitlement to any ratings for his right forearm.

There is no medical evidence of a chronic condition limiting repetitive use. Therefore, we also decline to provide a rating on this basis.

In summary, we find that claimant failed to prove any impairment resulting from his right arm condition and, therefore, we conclude that he is not entitled to scheduled permanent disability.

Permanent Total Disability

Additional permanent disability cannot be awarded unless claimant establishes a permanent worsening of his compensable condition since the last award or arrangement of compensation. Stepp v. SAIF, 304 Or 375 (1987); Bendix Home Systems v. Alonzo, 81 Or App 450 (1986).

Here, in light of our alternative conclusion that claimant is not entitled to additional scheduled permanent disability, we are not inclined to find that claimant's compensable condition has worsened. Thus, he would not be entitled to additional permanent disability, including permanent total disability. Stepp v. SAIF, supra; Bendix Home Systems v. Alonzo, supra. Nevertheless, assuming that claimant was entitled to an evaluation regarding his entitlement to permanent total disability, we would decline to grant such an award.

ORS 656.206(1)(a) states that "permanent total disability" "means the loss, including preexisting disability, of use or function of any scheduled or unscheduled portion of the body which permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation." Claimant contends that he is entitled to permanent total disability based on a preexisting cardiopulmonary disease, the May 1988 injury, and the right arm condition.

Under the statute, the extent of claimant's total impairment, including that caused by all disabling conditions, regardless of compensability, that preexisted the injury and the impairment resulting from the injury, is considered. Weyerhaeuser Company v. Rees, 85 Or App 325, 329 (1987). A disability is preexisting if it predates the injury. E.g. Elder v. Rosboro Lumber Co., 106 Or App 16, 18 (1991).

As we found above, claimant failed to prove any disability from his right arm condition. Therefore, because there was no proof that claimant's disability is attributable to this condition, claimant's entitlement to permanent total disability is based only on his May 1988 injury and preexisting cardiopulmonary condition.

We further find that, although symptomatic, claimant's cardiopulmonary condition was not disabling before the May 1988 injury. The earliest indication of disability from the cardiopulmonary condition is from a December 28, 1988 report stating that claimant "did have a rotator cuff tear and surgical repair on 5/31/88, and this has contributed to his disability, but the pulmonary problem seems to be his main cause of disability." (Ex. 30). We interpret this report as indicating that claimant's disability as of December 28, 1988 was in part due to the cardiopulmonary condition but contains no evidence that this condition was disabling as of the May 1988 injury. Therefore, because the cardiopulmonary condition does not qualify as a "preexisting disability" under ORS 656.206(1)(a), such condition may not be considered. Because claimant makes no contention that he is permanently and totally disabled based on impairment from his May 1988 injury alone, we conclude that he is not entitled to permanent total disability.

Rate of Scheduled Permanent Disability

Finally, claimant contends that he is entitled to a rate of $305 per degree for any scheduled permanent partial disability awarded for his right arm condition. Because claimant is not entitled to such a permanent disability award, we need not address this issue.

ORDER

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

In the Matter of the Compensation of
WAYNE M. PAXTON, Claimant
WCB Case No. 91-14254
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of those portions of Referee Brazeau's order which: (1) awarded claimant temporary partial disability from September 3, 1991 until proper closure of his claim; and (2) assessed a penalty equal to 25 percent of the temporary disability awarded by the order, to be divided equally between claimant and his attorney. On review, the issues are temporary disability benefits, penalties, and attorney fees.

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

We agree with the Referee's reasoning that Noffsinger v. Yoncalla Timber Products, 88 Or App 118 (1987) does not govern this case, since claimant was released only to modified, not regular, work at the time of his termination from employment for reasons unrelated to his injury. Because claimant remained disabled from performing his regular work at the time of his termination, he was entitled to continue to receive temporary disability benefits, regardless of the reason for the termination. See Roberta L. Jones-Lapeyre, 43 Van Natta 942, 944 (1991). Accordingly, we affirm the Referee's order.

Claimant seeks, by a motion to the Board, penalties and attorney fees under ORS 656.382(1) and (3), in addition to the penalty assessed by the Referee under ORS 656.262(10). Since the factual basis for assessing a penalty under ORS 656.262(10) is the same as the alleged basis for assessing penalty-related attorney fees under ORS 656.382(1), claimant is not entitled to attorney fees under the latter statute. Nicolasa Martinez, 43 Van Natta 1638 (1991), aff'd Martinez v. Dallas Nursing Home, 114 Or App 453 (1992). Neither is claimant entitled to a penalty under ORS 656.382(3), since claimant requested the hearing, not the employer. Moreover, claimant asserts entitlement to a penalty under ORS 656.382(3) for the first time on Board review. Accordingly, we deny claimant's motion.

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 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 temporary disability 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 January 10, 1992 is affirmed. Claimant's attorney is awarded $1,000 for services on Board review concerning the temporary disability issue, to be paid by the insurer.

In the Matter of the Compensation of
BOYD C. THORNTON, Claimant
WCB Case No. 92-02678
ORDER OF DISMISSAL (REMANDING)
Westmoreland & Shebley, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Claimant has requested, and the insurer has cross-requested, Board review of Referee Davis' July 21, 1992 order. We have reviewed the requests to determine whether we have jurisdiction to consider it. We conclude that jurisdiction rests with the Hearings Division.

FINDINGS OF FACT

The Referee's Opinion and Order issued July 21, 1992. On August 14, 1992, the insurer sought abatement and reconsideration of the Referee's order. On August 19, 1992, the Referee issued an Order of Abatement to consider the insurer's motion. That same day, claimant's request for review of the Referee's July 21, 1992 order was received by the Board. The insurer's cross-appeal was received by the Board on August 21, 1992.

CONCLUSIONS OF LAW

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

Here, the Referee abated his July 21, 1992 order on August 19, 1992. That same day, claimant's request for Board review of the Referee's order was received by the Board. Inasmuch as the Referee abated his order simultaneously with claimant's request for Board review, we shall give effect to the Order of Abatement. Accordingly, claimant's request, and the insurer's cross-request for Board review, are dismissed as premature. This matter is remanded to Referee Davis for further consideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
KENNETH A. BRESSON, Claimant
WCB Case No. 91-06444
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Brazeau, Hooton and Kinsley.

The insurer requests review of Referee Podnar's order that: (1) increased claimant's unscheduled disability award for a low back condition from 1 percent (3.2 degrees), as awarded by a Determination Order, to 40 percent (128 degrees); and (2) directed it to pay claimant's scheduled disability award at the rate of $305 per degree. On review, the issues are extent of unscheduled disability and rate of scheduled disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Disability

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

In rating the extent of claimant's unscheduled disability under the standards, the Referee awarded impairment values for lost range-of-motion findings reported by Dr. Becker during examinations performed in April and August 1991. On review, the insurer argues that the Referee should have relied on the less restrictive range-of-motion findings set forth in Dr. Becker's April 1990 closing exam, because they more accurately reflect claimant's permanent impairment.

We decline to address the insurer's contention, given the Referee's additional conclusion, with which we agree, that the record, as a whole, constitutes clear and convincing evidence that claimant is

more disabled than the entitlement indicated by the standards. Former ORS 656.283(7) and 656.295(5). As noted above, the medical evidence reveals that claimant demonstrated a wide variability of range-of-motion over time, which we believe indicates claimant's susceptibility to significant waxing and waning of symptoms. Moreover, claimant's need for retraining for sedentary work indicates an increased effect of disability on claimant not generally anticipated in the population as a whole. Accordingly, regardless of whether the Referee erred in rating the extent of claimant's permanent disability at 40 percent under the standards, we affirm the Referee's ultimate conclusion that claimant is 60 percent disabled as a whole.

Rate of Scheduled Disability

The Referee concluded that claimant's award of scheduled permanent disability should be paid at the rate of $305 per degree. He relied on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), in which we held that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. Subsequent to the Referee's order, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992).

In this case, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury, which, in this case is $145 per degree. ORS 656.202(2); former ORS 656.214(2).

Attorney Fee on 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 extent of unscheduled disability is $700, 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 September 19, 1991 is affirmed in part and reversed in part. That portion of the order that directed the insurer to pay claimant's scheduled disability award at the rate of $305 per degree is reversed. The remainder of the order is affirmed. For services on Board review regarding the extent of unscheduled disability issue, claimant's attorney is awarded an assessed fee of $700, to be paid by the insurer.

Board Member Kinsley dissenting.

I disagree that the record shows that claimant is entitled to benefits for 40 percent unscheduled disability. Specifically, I disagree with the majority's method of adding multiple residuals of impairment in the lumbar spine rather that combining them, and I disagree that claimant proved by clear and convincing evidence that his disability is more than that indicated by the standards adopted by the Director.

The parties conceded to, and I agree with, the Referee's use of the following values in determining claimant's award:

FACTOR	VALUE	RULE/STANDARD
Age: 41 years =	1	Former OAR 436-35-290(4)
Education:		
Formal education: high school =	0	Former OAR 436-35-300(3)(a)

Skills: highest specific vocational preparation level =	1	Former OAR 436-35-300(4)
Training: has training =	0	Former OAR 436-35-300(5)
Adaptability: ability to perform medium strength work decreased to light/sedentary work =	2.5	Former OAR 436-35-310(3)

To determine the award, I add the age value (1) and education values (0+1+0=1) together (1+1=2) and multiply by the adaptability factor (2.5) for a value of 5. Then I add the impairment value to 5 (as calculated below) to determine the total award. Former OAR 436-35-280.

Impairment

I agree with the Referee's holding that claimant's loss of range of lumbar motion should be measured on the basis of Dr. Becker's examination findings of August 5, 1991. Under the applicable law, disability is rated as of the date of hearing and these findings were closest in time to the hearing. Also, I agree that these findings do not merely represent a temporary exacerbation and can properly be considered as permanent impairment.

The parties conceded to, and I agree with, the Referee's use of the following values for claimant's surgery and repetitive use restrictions:

(1) Lost Range of Motion:

Range of lumbar motion:	VALUE	RULE/STANDARD
Flexion: 36 degrees =	5.4	Former OAR 438-35-360(6)-(9)
Extension: 12 degrees =	1.8	
Lateral Flexion:		Add these for
right: 12 degrees =	3.6	the total
left: 12 degrees =	3.6	Former OAR 436-35-360(10)
Rotation:		
right: 12 degrees =	3.6	
left: 12 degrees =	3.6	
	21.6	Total value for lost range of motion

(2) Surgery

Laminectomy with single discectomy =	5	Former OAR 436-35-350(2)
Fusion of two lumbar vertebrae =	3	Former OAR 436-35-350(3)

(3) Repetitive Use Limitation:

Chronic lumbar condition limiting repetitive use of the spine =	5	Former OAR 436-35-320(4)

Former OAR 436-35-360(11) requires that the above multiple residuals for loss of range of motion, surgery and limitation of repetitive use be combined, rather than added. However, the Referee added them. The combined total of 21.6, 5, 3 and 5 is 31.792. Former OAR 436-35-005(4). Adding this 31.792 value for permanent impairment to the previously calculated value of 5 for age, education and adaptability equals 36.792. This figure is rounded up for a total of 37 percent permanent disability of the low back. Former OAR 436-35-280(7). Claimant had a previous claim for low back injury which resulted in an award for 20 percent unscheduled disability. Therefore, since 20 percent of the present disability has already been compensated, claimant's total award in this case should be for 17 percent unscheduled permanent partial disability. ORS 656.214(5).

The Referee reached the 40 percent award on this claim by determining that claimant's overall low back disability was 60 percent and then subtracting the prior award. The Referee properly subtracted the prior award so that claimant's award in this case reflects only the additional disability caused by this injury. However, the Referee found that claimant had proved by clear and convincing

evidence that he has the overall disability of 60 percent, which exceeded that allowed under the disability rating rules, on the basis of the following three reasons:

1) "the necessity of claimant to be retrained in a light to sedentary job,"

2) "his need for ongoing palliative care to keep him employable as prescribed by Dr. Becker," and

3) "Dr. Becker's unequivocal assessment that claimant's range of motion is severely compromised due to his injury."

I disagree that these reasons entitled claimant to a greater award than allowed by the standards.

The first element of disability has been already accounted for in the director's standards in the adaptability factor. Former OAR 436-35-310(3). In fact, the sole purpose of the adaptability factor is to increase the award when a worker's decreased strength requires a modification in employment. I found no evidence in the record that would require an additional value for this factor not already covered by the rule.

The second reason is not a factor that, on its face, demonstrates permanent disability requiring an additional award. There has been no showing by claimant that the need for ongoing care somehow separately creates additional permanent disability not already accounted for in the remainder of the standards.

Finally, the third reason has thoroughly been accounted for in the above loss of lumbar range of motion calculations. Those calculations are based on findings most favorable to claimant and claimant has made no showing that his particular loss of range of motion was not already accounted for by the standards.

Based on the above, I would award claimant benefits for 17 percent unscheduled permanent partial disability due to this injury. I would not find that claimant has proved entitlement to greater benefits by clear and convincing evidence.

In the Matter of the Compensation of
SUZANNE DAY-HENRY, Claimant
WCB Case No. 91-09097
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Hooton and Brazeau.

Claimant requests review of Referee Daughtry's order that upheld the self-insured employer's denial of her aggravation claim for a herniated L4-5 disc. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the "FINDINGS OF FACT" section of the Referee's order.

CONCLUSIONS OF LAW AND OPINION

Because claimant filed her hearing request after May 1, 1990, and the hearing was convened after July 1, 1990, we analyze this case under the Workers' Compensation Law, as amended in 1990. See Or Laws 1990 (Special Session), ch 2, § 54; Ida M. Walker, 43 Van Natta 1402 (1991).

In order to establish a compensable aggravation, claimant must prove that her compensable 1988 injury has worsened since the last award of compensation. See ORS 656.273(1). The parties do not dispute that claimant's herniated disc condition, if compensably related to the 1988 injury, has worsened. The sole issue, therefore, is whether the herniated disc is compensably related to the 1988 injury.

Because there was no showing that claimant's herniated disc was in existence at the time of the 1988 injury or at any time prior to claim closure, the Referee analyzed the causation issue under ORS 656.005(7)(a)(A), which provides 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." Finding that claimant did not sustain her burden of proof under the major contributing cause standard, the Referee concluded that the herniated disc is not compensable. We disagree with the Referee's analysis.

Interpreting ORS 656.005(7)(a)(A), the Court of Appeals recently held that the major contributing cause test only applies to a condition or need for treatment that is caused by a compensable injury, whereas the material contributing cause test still applies to a condition or need for treatment that is directly caused by an industrial accident. Albany General Hospital v. Gasperino, 113 Or App 411, 415 (1992).

A delay in the onset of a condition following the compensable injury is not determinative of whether or not that condition is a "consequential condition." The facts of Gasperino are illustrative. There, the claimant slipped and fell at work, thereby sustaining various strains involving the right wrist, shoulder and neck area. She sought treatment and filed a claim, which was accepted. Over the next several months, she developed numbness and tingling down her arms into her hands. As her symptoms worsened, she was referred to various doctors who gave different diagnoses for her condition. Finally, more than a year after the industrial accident, she was diagnosed with thoracic outlet syndrome (TOS). The court concluded that, notwithstanding the belated onset of the TOS, that condition arose directly from the accident and, therefore, the claimant needed only to establish that the condition was materially caused by her industrial accident.

Here, we find that claimant's herniated L4-5 disc arose directly, though belatedly, from the 1988 industrial accident. Dr. Amstutz, the attending neurosurgeon, opined that claimant tore her disc annulus in the May 1988 injury and that the condition gradually progressed to a ruptured disc. (Ex. 64). We interpret Dr. Amstutz's opinion to mean that disc herniation occurred sometime after the May 1988 injury, but that the injury was a direct cause of its development. This theory is consistent with the balance of the medical record, which shows that claimant did not have definitive symptoms of disc herniation until sometime between October 31, 1990 and the April 1991 CT exam.

Given our finding that the herniated disc arose directly from the 1988 industrial accident, claimant must prove that the 1988 injury is a material contributing cause of the herniated disc. See ORS 656.005(7)(a). Dr. Amstutz's opinion supports a material causal relationship. Additionally, none of the other doctors rule out the 1988 injury as a material contributing cause of the disc condition. Accordingly, given the absence of any intervening injury, we find that the 1988 compensable injury is a material contributing cause of the herniated disc condition and the resulting need for treatment. Claimant's aggravation claim for the herniated disc is compensable.

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 $3,000, 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 appellate briefs and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated October 31, 1991 is reversed. The self-insured employer's denial of aggravation is set aside and the claim is remanded to the employer for processing according to law.

Claimant's attorney is awarded $3,000 for services at hearing and on Board review, to be paid by the self-insured employer.

September, 17, 1992 Cite as 44 Van Natta 1794 (1992)

In the Matter of the Compensation of
THOMAS W. DOYLE, Claimant
WCB Case No. 91-09569
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Kinsley, Brazeau and Hooton.

The self-insured employer requests review of Referee Leahy'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

Claimant, 35 years old at hearing, worked as a retail food clerk for the employer. On March 13, 1991, he experienced an acute episode of right low back pain while bending to pick up firewood at his home. He sought immediate treatment at a local hospital, where he was given medication and referred to Dr. Meyers.

Dr. Meyers examined claimant on March 15, 1991, at which time claimant complained of back pain that radiated down the right hip and leg. Claimant reported that the pain had started one or two days earlier when he bent over while working in his yard. In a chart note, Dr. Meyers wrote that the injury was not an on-the-job injury and prescribed bed rest.

By May 1991, claimant had developed a mild foot drop with pain and numbness. He began treating with Dr. Tanabe, to whom claimant reported that, prior to the bending incident at home, he had "developed soreness in his right buttocks area." (Ex. 4-1). Dr. Tanabe diagnosed probable foraminal disc herniation and ordered an MRI scan, which later revealed a mild degenerative disc at L5-S1.

On May 22, 1991, claimant filed an 801 form with his employer, seeking compensation for a bulged disc. On the form, he explained the accident as follows:

> "I noticed a pain in my right buttocks while stocking. I figured it was a pulled muscle. This was approximately [sic] 3-7-91. On 3-13-91 I bent over to pick up a piece of wood at my house and felt a shooting pain down my leg and foot." (Ex. 8-1).

The employer denied the claim, asserting that there was insufficient evidence that claimant's condition arose out of the course of his employment.

On June 24, 1991, claimant returned to Dr. Tanabe and provided additional history that he first noticed the pain in his right buttocks while bending over and putting dog food onto some low shelves at work in early March.

On October 2, 1991, claimant was examined by Drs. Brown and Laycoe at the offices of MedReview, where claimant reported that he had first injured his low back on March 7, 1991 while bending over to lift a 40-pound sack of dog food. Based on that history, the doctors concluded that it was medically probable that the on-the-job injury was a material contributing cause of claimant's current low back condition.

On October 16, 1991, Dr. Meyers reported that claimant failed to mention an on-the-job injury during the initial March 15, 1991 consultation and had attributed his low back pain to the bending

incident at home. Based on claimant's complaints, history and the emergency room records, Dr. Meyers opined that claimant's low back pain was not related to his work.

CONCLUSIONS OF LAW AND OPINION

The issue is whether claimant's current low back condition, diagnosed as a degenerate L5-S1 disc with a small bulge, arose out of and in the course of his employment. The employer contends that it did not and argues that claimant fabricated the incident of having injured himself while lifting a bag of dog food on March 7, 1991.

The Referee did not make a specific credibility finding, stating only that he found claimant at least as credible as the employer's witnesses. Nonetheless, we are equally capable of assessing credibility based on an objective evaluation of the documentary evidence and claimant's testimony. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). After our review of the record, we find inconsistencies and unexplained discrepancies that cast doubt on his reliability. For example, while he maintains that he first experienced pain stocking shelves on March 7, he made no mention of a work-related injury when he sought treatment at a local hospital on March 13. Rather, the emergency room record indicates that claimant had simply reported that the pain started "while bending over at home." (Ex. 1-A). Furthermore, when claimant saw Dr. Meyers on March 15, he made no mention of the alleged work injury and reported that the pain "started a couple of days ago when he just bent over." (Ex. 1-1). In fact, after further questioning about the cause of the pain, Dr. Meyers concluded that it was not an on-the-job injury.

The record also reveals that claimant failed to report any specific work-related injury to his supervisors. David Walter, the store manager, testified that he had kept in communication with claimant during the course of treatment and that claimant never mentioned any work-related cause of his back problems. Kevin Webster, claimant's supervisor, testified that, prior to March 13, claimant had complained of back pain during a casual conversation. He further explained, however, that claimant did not report a specific injury and added that it was common for stockers, such as claimant, to complain about pain from lifting heavy loads.

In summary we do not find the substance of claimant's testimony credible. For that reason, we give little weight to the opinions of Drs. Brown and Laycoe, who concluded that claimant's March 7, 1991 work injury was a material cause of his current back problems. A medical opinion is no better than the history on which it is based. Miller v. Granite Construction Co., 28 Or App 473 (1977). Instead, we rely on the opinion of Dr. Meyers, who opined that claimant's low back pain was not related to his work, and conclude that claimant has failed to establish a compensable claim.

ORDER

The Referee's order dated November 5, 1991 is reversed. The self-insured employer's denial is reinstated and upheld. The Referee's assessed attorney fee award is also reversed.

Board Member Hooton dissenting.

The majority states that "[t]he Referee did not make a specific credibility finding, stating only that he found claimant at least as credible as the employer's witnesses." I would read that as a specific credibility finding. The Referee clearly indicates that the claimant is as believable as any other witness. The Referee does not indicate whether the foundation of that determination is rooted solely in the evidence presented or whether it also is based upon the demeanor of the witnesses at hearing. In the absence of a specific finding that claimant was not credible based on demeanor evidence I would presume that claimant's demeanor provided the Referee with no indication that claimant was other than truthful in his testimony.

I acknowledge that the Board is equally capable of assessing credibility where that finding is based solely on the documentary evidence and the claimant's testimony. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). I also accept that the Board may set aside a finding of credibility, even if based on demeanor, and must provide only those findings which form the basis of that opinion. Erck v. Brown Oldsmobile, 311 Or 519 (1991).

In Erck the Supreme Court indicated that it is sound practice for an agency or court to give weight to the factfinder's credibility assessments. It suggested that the factfinder's unique opportunity to observe the *witnesses provides a perspective that is not available to the reviewing body. Despite its suggestion regarding what an agency or court ought to do, the Court concluded that there was no legal mandate requiring deference. Id. at 525, 526.

As a parent and a lawyer, I frequently note the human propensity to ignore the sound warnings and advice that accompany permission and authority. Rather than conform our conduct to suggested limitations, we forge ahead in exploring the boundaries of our newfound powers.

I do not assert that this Board should never reverse the credibility findings of a referee. I do believe, however, that we should limit the exercise of authority to those situations in which the record evidence supporting a contrary finding is, if not overwhelming, at least sufficiently strong that demeanor at the time of hearing could not be viewed as sufficient to tip the scales one way or the other. This is not such a case.

The majority cites "inconsistencies and unexplained discrepancies that cast doubt on [claimant's] reliability" as the reason for its reversal on credibility grounds. I would find that the record raises questions, but does not establish that claimant is an unreliable witness.

The majority relies upon the fact that claimant initially reported a bending incident at home on March 13 as the cause of his back pain. The record reflects that claimant experienced back soreness prior to March 13, but that disabling pain did not arise before the March 13 incident. I find no inconsistency or discrepancy.

The majority goes on to note that "after further questioning about the cause of pain, Dr. Meyers concluded that it was not an on-the-job injury." This finding is actually contrary to evidence in the record. Dr. Meyers reported that he had no independent recollection of the questions which he asked claimant and could not verify that he questioned him at all about a potential on-the-job cause of his complaints other than to note his standard practice. (Ex. 15). Without knowing what Dr. Meyer asked, we are without a basis to determine whether claimant's subsequent histories are inconsistent or unreliable. Dr. Meyers openly relies upon the history provided by the examining physician in the emergency room to conclude that the injury was not an on-the-job injury, but that history is not inconsistent with the facts asserted by claimant. Disabling pain, as distinguished from mere soreness, did arise on March 13 as a result of a bending episode at home. Dr. Meyers ultimately notes that it was not himself, but Dr. Tanabe, who took the history on March 15. (Ex. 15). Indeed, if any evidence in the present record is unreliable, it is the October 16, 1991 report of Dr. Meyer. His exasperation with continued questioning is readily apparent, and the report is internally inconsistent and contradictory.

Claimant testified that he did not report the at- work incident of March 7 for fear of losing his job or of placing himself in disfavor with his employer. That explanation, even without confirmation that it is justified, is believable. In addition, the record indicates that the employer was aware that heavy lifting at work frequently resulted in complaints of back pain, even though no claims were filed. Claimant's actions were apparently consistent with those of the majority of his coworkers.

While I accept that the evidence raises a "question" or "doubt" regarding claimant's credibility, I do not find evidence which would support a finding that claimant is "not credible." A finding that claimant is not credible is supported by substantial evidence, if the evidence on which that finding is based makes it more likely than not that the finding is correct. In this case, the evidence does not rise to that level. Indeed, claimant's story, in light of his report of back pain to his supervisor prior to March 13, remains more likely true than false. Under the circumstances, the Referee's opportunity to observe the witnesses gave him a decided advantage in making this determination. Absent that advantage, the present finding on credibility is pure speculation. Speculation, by definition, is not supported by substantial evidence.

In the Matter of the Compensation of
FELIPA SALAZAR, Claimant
WCB Case No. 91-12368
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Kevin L. Mannix, P.C., Defense Attorneys
Les Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Myers' order which: (1) set aside an Order on Reconsideration on the ground that it was invalidly issued; and (2) found that jurisdiction over this matter remained with the Appellate Unit of the Workers' Compensation Division (WCD). In her appellant's brief, claimant requests that we remand this matter to the WCD Appellate Unit for further proceedings consistent with ORS 656.268(7). On review, the issues are the validity of the WCD's Order on Reconsideration and remand. We affirm.

FINDINGS OF FACT

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

On June 20, 1989, claimant sustained a compensable injury to her right foot and back. Her claim was closed by a February 5, 1991 Determination Order which awarded no scheduled or unscheduled permanent disability.

On November 18, 1991, subsequent to the issuance of the WCD Appellate Unit's Order on Reconsideration, claimant was examined by a medical arbiter, the Orthopaedic Consultants.

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 found that jurisdiction remained with the WCD Appellate Unit. We agree that the arbiter's report had to be submitted to the Department before a valid Order on Reconsideration could issue.

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), ch. 2 §54(3). Additionally, 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 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, 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) recon den, 44 Van Natta 1609 (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 used in that order. The Order on Reconsideration was issued before the medical arbiter had examined claimant and reported their findings. Thus, the medical arbiter's findings were not submitted to the Department before the Order on Reconsideration was issued as required by ORS 656.268(7).

Where the Director does not comply with the mandatory procedure set forth in ORS 656.268(7), and one of the parties objects to the order issued, the Order on Reconsideration is invalid. Olga I. Soto, supra. Here, although claimant challenged the 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. On review, claimant objects to the Order on Reconsideration as issued. Under such circumstances, we conclude that the Order on Reconsideration is invalid.

Remand

In affirming the Referee's order, we note that claimant also requests that we remand this matter to the WCD Appellate Unit for further proceedings consistent with ORS 656.268(7). However, neither the Referee nor the Board is authorized to "remand" the case to the WCD Appellate Unit. See Mickey L. Platz, 44 Van Natta 1056 (1992). Consequently, since the Order on Reconsideration is found to be invalid, jurisdiction over the dispute remains 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 29, 1991, as amended December 6, 1991, is affirmed.

Board member Hooton, specially concurring.

I agree with that portion of the Order on Review which finds the Order on Reconsideration invalid. I am sympathetic to claimant's request for a formal remand to the Department. As noted in my concurring opinion in the Order Denying Reconsideration in Olga I. Soto, 44 Van Natta 1609, 1610 (1992) the insertion of the Appellate Unit into the chain of review suggests that remand authority is an essential and necessary component of Board authority in extent of disability cases. For that reason, I disagree with the conclusions of one panel of the Board as outlined in Mickey L. Platz, 44 Van Natta 1056 (1992).

As noted in the concurrence in the Order Denying Reconsideration in Olga I. Soto, supra, however, there is no practical distinction between an Order invalidating an Order on Reconsideration, and an Order remanding to the Department. In each case, the claim is, or remains, before the Department for further action, and the Department is no more likely to act on either form of order. Because the claim is where the claimant wants it to be, no further action on our part is required.

In the Matter of the Compensation of
WILLIAM J. AMACKER, Claimant
Own Motion No. 92-0451M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable left knee injury. Claimant's aggravation rights expired on December 5, 1991. SAIF opposes authorization of temporary disability compensation, contending 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.

We conclude that claimant has sustained such a worsening. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, but is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

On January 29, 1992, Dr. Chamberlain of Medford Orthopedic Group, Inc. wrote to the claims adjuster at SAIF. Dr. Chamberlain reported that, "I do not believe that his current occupation has contributed to the need for knee surgery." Further, Dr. Chamberlain remarked that, "As to the patient's employment history, that does not necessarily fall under the realm of my medical history taking. Although I would state at this point in time that it is not the cause of his difficulties with his knee."

Under the circumstances we conclude that claimant remained in the work force at the time of his hospitalization for surgery. See Robert L. Adler, 44 Van Natta 1478 (92).

Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning August 13, 1992, the date he was hospitalized for surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-12-055.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARTHA A. BENEFIEL, Claimant
WCB Case No. 90-06226
ORDER ON REMAND
Moomaw, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Benefiel v. Waremart, Inc., 112 Or App 480 (1992), rev den 313 Or 627 (1992). The court has reversed a Board order which adopted a Referee's order upholding the insurer's denial of claimant's right knee injury claim. The Referee had found that claimant had not established that her knee injury was work-related because her fall at work was unexplained. Reasoning that claimant had gone to work in a weakened physical condition due to the flu and had performed stressful work activities as a grocery checker, the court concluded that her fall at work from fainting was not unexplained. Holding that there was "no evidence to support the Board's finding that claimant's work did not contribute to her injury," the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the "Findings of Fact" as contained in the Referee's order with the exception of the last sentence. We add the following finding of ultimate fact. Claimant's hectic and stressful work activities as a grocery checker on January 10, 1990 were a material contributing cause of her fainting, which caused her fall and her right knee injury.

CONCLUSIONS OF LAW

As discussed above, the court held that claimant's fall at work was not unexplained. Rather, the court concluded that claimant fainted because she performed stressful work activities while in a weakened physical condition. Determining that there was "no evidence to support the Board's finding that claimant's work did not contribute to her injury," the court has remanded for reconsideration.

In reaching its conclusion, the court noted that the insurer has conceded that claimant's ailment was not a complex medical condition which required expert evidence to establish its cause. Consequently, the court reasoned that claimant was competent to testify concerning how her condition impaired her ability to perform her job.

In light of the court's conclusions and after considering claimant's credible testimony, we find that claimant's hectic and stressful work activities as a grocery checker on the day in question were a material contributing cause of her fainting and fall. Inasmuch as claimant's fall resulted in her right knee injury, we hold that the insurer is responsible for medical services and disability for her right knee condition. Former ORS 656.005(7); Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979).

Accordingly, on reconsideration, the Referee's order dated September 10, 1990 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law.

IT IS SO ORDERED.

In the Matter of the Compensation of
KENNETH W. HOWELL, Claimant
Own Motion No. 92-0485M
OWN MOTION ORDER
Starr & Vinson, Claimant Attorneys
Employers Insurance of Wausau, Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for his compensable left wrist injury. Claimant's aggravation rights expired on April 8, 1992. The insurer recommends that we authorize the payment of 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.

We are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning the date he is hospitalized for the proposed surgery.

Claimant's condition worsened and his claim is reopened within the time for appeal of a July 6, 1992 Determination Order. Therefore, this claim must be reclosed under ORS 656.268 rather than ORS 656.278. Carter v. SAIF, 52 Or App 1027 (1981). Therefore, when appropriate, the claim shall be submitted to Evaluation Unit of the Benefit Section of the Worker's Compensation Division or closed by the insurer as is apprropriate under ORS 656.268 rather that pursuant to OAR 438-12-055.

Finally, the insurer is allowed to offset time loss paid beyond the medically stationary date against any future award of permanent disability.

IT IS SO ORDERED.

In the Matter of the Compensation of
LINDA J. HUGHES-SMITH, Claimant
WCB Case Nos. 91-00385 & 90-21932
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Hooton.

The SAIF Corporation requests review of Referee Quillinan's order that assessed penalties for its allegedly unreasonable delay in paying and refusal to pay compensation pursuant to a prior Referee's order pending Board review of the prior order. On review, the issue is penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

Pursuant to claimant's hearing requests filed before May 1, 1990, a hearing was convened before a prior Referee on June 28, 1990, concerning a Determination Order that awarded claimant benefits for unscheduled permanent partial disability and temporary total disability. By Opinion and Order dated September 13, 1990, the prior Referee awarded claimant an additional 37 percent unscheduled permanent disability benefits and additional temporary total disability benefits for the period from May 4, 1988 to September 12, 1988.

SAIF requested Board review of only that portion of the prior Referee's order that awarded additional permanent disability benefits. SAIF did not appeal the Referee's award of temporary disability benefits. See Linda Hughes-Smith, 43 Van Natta 1517, on recon 43 Van Natta 1721 (1991).

SAIF paid the prior Referee's award of temporary total disability benefits on October 1, 1990, which was more than 14 days after the September 13, 1990 order. SAIF did not pay any of the prior Referee's award of 37 percent unscheduled permanent disability benefits.

Claimant filed the current hearing request seeking penalties for SAIF's allegedly late payment of temporary total disability benefits and refusal to pay permanent partial disability benefits pending Board review of the September 13, 1990 order.

CONCLUSIONS OF LAW AND OPINION

The resolution of this case turns on whether or not SAIF was authorized to stay the payment of compensation pending Board review of the prior Referee's order. That issue rests, in turn, on the question of whether this case is governed by the current or former version of ORS 656.313.

Former ORS 656.313(1) provided that the "[f]iling by an employer or the insurer of a request for review * * * shall not stay payment of compensation to a claimant." The 1990 Legislature then amended ORS 656.313 to provide, in pertinent part:

> "(1)(a) Filing by an employer or the insurer of * * * a request for board review * * * stays payment of the compensation appealed, except for:
>
> "(A) Temporary disability benefits that accrue from the date of the order appealed from until closure under ORS 656.268, or until the order appealed from is itself reversed, whichever event first occurs."

The temporary disability benefits in dispute here did not accrue from the date of the prior Referee's order and, thus, are not excluded from the current stay provision.

The 1990 legislative amendments, including those to ORS 656.313, generally became operative on July 1, 1990. Or Laws 1990 (Special Session), ch 2, § 54(1). An exception to that rule is found in section 54(2) of those amendments:

> "Any matter regarding a claim which is in litigation before the Hearings Division, the board, the Court of Appeals or the Supreme Court under this chapter, and regarding which matter a request for hearing was filed before May 1, 1990, and a hearing was convened before July 1, 1990, shall be determined pursuant to the law in effect before July 1, 1990."

Reasoning that claimant had filed her hearing request before May 1, 1990, and a hearing was convened before July 1, 1990, the Referee concluded that section 54(2) applies to this case. She, therefore, applied former ORS 656.313 to hold that SAIF could not stay payment of compensation pending Board review. We disagree.

In determining whether section 54(2) applied to this proceeding, the Referee considered the issues in the prior hearing which were claimant's entitlement to temporary disability and permanent disability benefits. Those issues are separate and distinct from the matter "in litigation" here, i.e., whether SAIF could stay payment of compensation pending Board review. Indeed, SAIF's claim processing obligations and, correspondingly, claimant's objection to SAIF's claim processing were a separate procedural matter which did not arise until after the issuance of the prior Referee's determination regarding the extent of disability. See Raymond J. Seebach, 43 Van Natta 2687 (1991).

Inasmuch as claimant's hearing request concerning this claim processing matter was not filed before May 1, 1990, and a hearing was not convened before July 1, 1990, section 54(2) of the 1990 amendments does not apply. Instead, we conclude that the current version of ORS 656.313, which took effect July 1, 1990, applies to this case.

Under amended ORS 656.313, the filing of a request for Board review stays payment of "the compensation appealed." Here, SAIF only appealed the prior Referee's award of permanent partial disability benefits; it did not appeal the Referee's award of temporary disability benefits. Accordingly, we conclude that the temporary disability benefits did not qualify as "compensation appealed." Therefore, amended ORS 656.313 did not operate to stay the payment of temporary disability benefits awarded by the prior Referee; it authorized a stay of only permanent disability benefits.

Because SAIF was authorized to stay payment of permanent disability benefits awarded by the prior Referee's September 13, 1990 order, a penalty may not be assessed for SAIF's refusal to pay those benefits pending its appeal.

On the other hand, SAIF was not permitted to stay the payment of temporary disability benefits. Indeed, SAIF conceded at hearing that its payment of temporary disability benefits was untimely. (Tr. 1). Inasmuch as SAIF offers no reasonable explanation for its delay, we find its conduct to be unreasonable. We agree with the Referee's assessment of a penalty equal to 10 percent of all temporary disability benefits that were not timely paid pursuant to the prior Referee's order.

ORDER

The Referee's order dated March 6, 1991 is reversed in part and affirmed in part. That portion of the order that assessed a 25-percent penalty based on permanent disability benefits is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
MAXINE R. KENDALL, Claimant
WCB Case No. 92-05828
ORDER OF DISMISSAL
Tooze, et al., Attorneys

Claimant, pro se, has requested review of Referee Podnar's July 23, 1992 order. We have reviewed the request to determine whether we have jurisdiction to consider the matter. Because the record does not establish that notice of claimant's request was timely provided to the other parties, we dismiss the request for review.

FINDINGS OF FACT

The Referee issued his order on July 23, 1992. On August 20, 1992, the Board received claimant's request for Board review of the Referee's order. The request did not indicate that copies of the request had been provided to the employer or its insurer.

On August 26, 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).

Claimant filed her request for review with the Board within 30 days of the Referee's July 23, 1992 order. Therefore, her request for review is timely. ORS 656.289(3).

Nevertheless, there is no indication in the record that either the employer or its insurer was provided with a copy, or received actual knowledge, of claimant's request for review within the statutory 30-day period for appealing the Referee's order. ORS 656.289(3); 656.295(2). Rather, the record suggests that the other parties' first notice of claimant's appeal occurred when they received the Board's August 26, 1992 acknowledgment letter. Therefore, we presume that the other parties did not receive notice of claimant's request for review within 30 days of the Referee's July 23, 1992 order. This presumption shall stand unless, within 30 days of this order, claimant establishes otherwise.

Consequently, we hold that notice of claimant's request for Board review to the other party was untimely. Therefore, we lack authority to review the order which has become final by operation of law. See ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, supra; Robert G. Ebbert, 40 Van Natta 67 (1988).

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
ANTHONY R. NEMETH, Claimant
WCB Case No. C2-01382
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Robert J. Guarrasi, Claimant Attorney

Reviewed by Board Members Neidig and Moller.

On August 18, 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.

Here, the agreement, on page one, recites that out of a total consideration in the amount of $6,000, an attorney fee is provided in the amount of $1,500. However, on page three, the agreement provides that claimant's attorney shall receive an attorney fee in the amount of $1,375.

Claimant has submitted a cover letter dated August 14, 1992 with the proposed agreement. By handwritten addendum dated August 17, 1992, claimant recites: "Rob, on page 3, line 14 of the CDA, it still says $1375 to you. I believe this is unimportant as page 1 is right I am submitting 'as is'. Tony"

Upon review of the document as a whole, we approve the proposed agreement for a total consideration of $6,000 with an attorney fee provided out of the total consideration in the amount of $1,500.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1). Accordingly, this claim disposition agreement is approved. An attorney fee payable to claimant's attorney according to terms of the summary page of the agreement is also approved.

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).

IT IS SO ORDERED.

In the Matter of the Compensation of
GLORIA J. PARR, Claimant
WCB Case No. 91-05221
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Gruber's order which: (1) dismissed claimant's hearing request; (2) found that the Hearings Division lacked jurisdiction to consider a medical services claim for prescription medications which had been "de facto" denied by the insurer; and (3) declined to assess penalties and attorney fees for the insurer's allegedly unreasonable "de facto" denial. On review, the issues are jurisdiction, 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 and supplementation. We do not adopt the last sentence of the first paragraph and the first sentence of the second paragraph.

Claimant's attending physician following her compensable cervical injury was Dr. Roy, M.D. (Ex. 17, 20). After her claim was first closed by a January 13, 1987 Determination Order, claimant received treatment for her compensable cervical condition from the Oregon Pain Center and from Dr. Balter, chiropractor. On or about November 18, 1988, claimant began treating with Dr. Lorenz, M.D., for her general medical care on an intermittent basis. (Exs. 60-1, 61-4). Dr. Lorenz did not examine claimant's back condition. (Ex. 60-1).

During the period from September 1990 through April 1991, Dr. Lorenz prescribed for claimant the prescription medications Fiorinal with codeine and Cyclobenzaprine. (Exs. 52, 53, 57).

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).

Jurisdiction and Compensability

Based on our decision in Stanley Meyers, 43 Van Natta 2643 (1991), the Referee found that the Hearings Division did not have original jurisdiction over the issue of whether the prescribed medications in question were reasonable and necessary for the treatment of claimant's compensable cervical condition. We adopt the Referee's reasoning and conclusions regarding that issue. We also note that, to the extent that the insurer contended that it denied the prescribed medications on the basis that they were palliative care, issues regarding palliative care are within the exclusive jurisdiction of the Director. Rexi L. Nicholson, 44 Van Natta 1546 (1992).

However, the parties also raised the issue of whether the prescribed medications are causally related to the compensable cervical injury. (Tr. 2-8). The Referee did not address that issue in his order. On review, the parties again argue the issue of causation. Although we do not have jurisdiction over the reasonableness and necessity of the prescription medications, 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.

Therefore, we proceed to the merits of the issue of causation. 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). Dr. Lorenz prescribed the medication in question. (Exs. 52, 53, 57). In response to a July 22, 1991 inquiry from claimant's attorney, Dr. Lorenz checked the box indicating that the medications were "prescribed to treat Ms. Parr for her 2/12/86 industrial injury." (Ex. 60-1). However, any persuasiveness that that "check-the-box" response has is negated by Dr. Lorenz's comments regarding that response. Dr. Lorenz stated as follows:

> "This patient has requested refills of medications used for chronic back pain, attributed to a back injury from a fall when previously employed. That condition was initially evaluated and treated by Dr. Oppenheimer and Barnhart. No new xrays have been obtained. We have agreed to refill these medications and if utilized frequently and regularly a review of her back condition would be warranted. This would require an examination, and possibly xrays. At this time we have refilled these medications on request of the patient who is normally followed for general medical care." (Ex. 60-1).

These statements reflect that Dr. Lorenz has an inaccurate understanding of the mechanism of claimant's cervical injury which did not occur as the result of a fall. More importantly, although Dr. Lorenz checked-the-box indicating that the prescribed medication was for treatment of the compensable injury, he has not examined or treated claimant for the compensable cervical injury. In addition, there are no medical reports in the record from Drs. Oppenheimer and Barnhart, who, according to Dr. Lorenz, initially treated claimant's back condition. Furthermore, the only other report from Dr. Lorenz does not mention any cervical condition and instead appears to relate the need for treatment to anxiety and situational stress. (Ex. 61). We do not find that Dr. Lorenz's reports establish

that the compensable cervical injury is a material cause of the need for the prescription medications in question. There are no other opinions in the record regarding causation. Therefore, claimant has not established the necessary causal relationship.

Penalties and Attorney Fees

We adopt the Referee's reasoning and conclusion on the issue of penalties and attorney fee with the following supplementation.

In order for unreasonable resistance to the payment of compensation to be found, the claim must have been compensable. Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991). Here, we have found that the prescriptions in question are not compensable because they are not causally related to the compensable injury. Therefore, no penalty or attorney fees may be assessed.

ORDER

The Referee's order dated December 18, 1991 is affirmed in part and reversed in part. The order is reversed to the extent that it dismissed claimant's hearing request as to the issue of the causal relationship between the prescribed medications and the compensable cervical condition. The "de facto" denial is upheld in so far as the insurer denied the causal relationship between the prescribed medications and the compensable cervical condition. The remainder of the order is affirmed.

In the Matter of the Compensation of
JOHN POSHYWAK, Claimant
WCB Case No. 91-09055
ORDER ON REVIEW
Ainsworth, et al., Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of that portion of Referee Brown's order that declined to award attorney fees relating to the SAIF Corporation's medical services denial. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

On October 16, 1988, claimant compensably injured his right lower chest while working as a prison guard. SAIF accepted the claim for a sixth intercostal rib fracture and provided benefits. Pursuant to a May 16, 1990 Stipulation and Order, claimant was awarded benefits for 15 percent unscheduled permanent partial disability.

Claimant continued to experience chest discomfort and, in January 1991, sought treatment from Dr. Loncar, a thoracic surgeon. Loncar concluded that claimant's symptoms were related to the prior injury and its failure to heal properly and recommended surgery. On May 17, 1991, SAIF wrote claimant:

> "We have recently received information that you wish to reopen your claim because of an alleged worsening of your condition and that you are seeking a surgical treatment which is allegedly related to your injury. After reviewing the information in your file, we are unable to pay for that treatment and reopen your claim.
>
> "A review of your file reveals lack of objective findings, no worsening since the last arrangement of compensation, and substantial medical opinions in opposition to surgery as reasonable and necessary for the accepted claim. Therefore, we must deny your request to reopen the claim." (Ex. 13).

Claimant subsequently requested a hearing on the denial.

CONCLUSIONS OF LAW AND OPINION

Claimant seeks review of the Referee's denial of his request for attorney fees under ORS 656.386(1). Claimant contends that he is entitled to an attorney fee, because he prevailed against a denial of a claim for compensation. We disagree.

At hearing, claimant's attorney acknowledged that no aggravation claim had been filed and that the only issue was the reasonableness of the proposed surgery. (Tr. 3 and 4). SAIF's counsel essentially agreed, and clarified that SAIF did not dispute the compensability of claimant's accepted condition. Accordingly, the Referee affirmed SAIF's May 17, 1991 denial, to the extent that it purported to deny an aggravation claim. The Referee also concluded that, under Stanley Meyers, 43 Van Natta 2643 (1991), he lacked jurisdiction to review the medical services portion of the denial, because it did not raise a "matter concerning a claim," within the original jurisdiction of the Hearings Division.

Neither party disputes either of those conclusions on review. Nonetheless, claimant contends that he is entitled to an attorney fee for "prevailing at hearing." (App. Brief at 5). He notes that, in the May 16, 1990 Stipulation and Order, SAIF agreed to provide treatment for claimant's rib fracture "as is reasonably related to the acceptable [sic] condition pursuant to ORS 656.245." (Ex. 4). Claimant then appears to read the May 17, 1991 denial as a refusal by SAIF to provide such treatment, and evidently believes that he is entitled to an attorney fee for obtaining a clarification at hearing that SAIF is not denying the compensability of claimant's rib condition.

We do not agree with claimant's apparent characterization of the relevant documents. We agree that, pursuant to the stipulation, SAIF agreed to provide appropriate medical treatment under ORS 656.245. We do not agree, however, that SAIF's denial of the proposed surgery on the basis that it was not reasonable and necessary treatment constituted a breach of that stipulation. To the contrary, such a denial appears to be contemplated within the plain language of the agreement. Inasmuch as compensation of the accepted condition was never at issue, we do not believe that claimant is entitled to an attorney fee for obtaining SAIF's concession to that effect at hearing.[1]

ORDER

The Referee's order dated January 9, 1992 is affirmed.

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[1] We note that, in his reply brief, claimant also argues that he is entitled to a an attorney fee because the Referee found in claimant's favor on the aggravation issue. Given claimant's concession that no aggravation claim had been made and the Referee's conclusion to that effect, the argument lacks merit and we decline to address it.

In the Matter of the Compensation of
ARNOLD G. WHEELER, Claimant
Own Motion No. 66-0332M
OWN MOTION ORDER
Vick & Gutzler, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has requested reconsideration of our prior orders in WCB Case No. 87-0276M that for lack of jurisdiction, denied its request for reevaluation of claimant's permanent total disability award arising from a pre-1966 compensable injury. This date, we have denied SAIF's request for reconsideration in WCB Case No. 87-0276M. However, we hereby treat SAIF's motion for reconsideration as a new request for Own Motion Relief.

In May 1987, SAIF petitioned the Board for reevaluation of claimant's permanent total disability award. In June 1987, the Board referred this matter to a Referee for an evidentiary hearing and recommendation concerning claimant's permanent total disability award. On May 25, 1988, a hearing was held by the Referee. On June 20, 1988, the Referee issued an order recommending that claimant's permanent total disability award be terminated.

On December 15, 1989, we issued an Own Motion Order in WCB Case No. 87-1276M in which we denied SAIF's request for own motion relief on the basis that we lacked jurisdiction to reevaluate claimant's permanent total disability award. Arnold G. Wheeler, 41 Van Natta 2362 (1989). On Reconsideration we adhered to that order. Arnold G. Wheeler, 42 Van Natta 356 (1990). Thereafter, SAIF petitioned the Court of Appeals for judicial review.

Initially, the court held that pursuant to ORS 656.278, the Board had jurisdiction to reevaluate claimant's permanent total disability award. SAIF v. Wheeler, 107 Or App 254 (1991). The court therefore reversed and remanded the matter to the Board. However, on reconsideration, the court concluded that it lacked jurisdiction over SAIF's appeal and consequently dismissed SAIF's petition for review. SAIF v. Wheeler, 110 Or App 453 (1992). Thereafter, the Supreme Court denied SAIF's petition for review. SAIF v. Wheeler, 313 Or 300 (1992).

In its initial decision, the Court of Appeals noted that the amendment to ORS 656.278(1) abolished the Board's authority to award permanent disability on its own motion. SAIF v. Wheeler, 107 Or App at 257. The court held, however, that the amendments did not limit the Board's authority to reduce or terminate a permanent disability award for injuries pre-dating 1966. Id.

Although the court ultimately dismissed SAIF's petition for lack of jurisdiction, we are persuaded by its initial decision regarding our authority to reevaluate awards of permanent disability for injuries pre-dating 1966. We conclude, therefore, that under the current version of ORS 656.278 we retain the authority to reduce or terminate awards of permanent disability for injuries that occurred prior to January 1, 1966.

Inasmuch as we have concluded that we have the authority to reevaluate claimant's 1968 permanent total disability award, we shall proceed to do so. In conducting our reevaluation, we will rely on the record developed at the May 1988 hearing. However, given the length of time between that hearing and the present, the parties are granted the opportunity to provide additional evidence, if any, regarding claimant's physical condition and ability to regularly perform a gainful and suitable occupation between May 1988 and the present.

Before proceeding with its review, the Board implements the following briefing schedule. SAIF's opening brief, including any supporting documents, is due 21 days form the date of this order. Claimant's response to SAIF's brief, including any supporting documents, should be filed within 21 days from the mailing of SAIF's brief. SAIF's reply should be filed within 14 days from the date of mailing of claimant's response. In the event that a party desires another fact-finding hearing, that party should include such request (including the reasons for the request) in his/her respective brief.

If further information is required, the parties will be notified. Once the Board is satisfied that an adequate record has been developed, the Board will take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
DON M. BOLDMAN, Claimant
WCB Case No. 91-04669
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Terrall & Associates, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Herman's order which: (1) found that claimant's back injury aggravation claim was prematurely closed; (2) directed the insurer to pay the increased permanent disability award made in an April 12, 1991 Order on Reconsideration in the amount of $2,880; (3) declined to authorize an offset of an alleged overpayment against future awards of permanent disability; and (4) assessed a penalty and attorney fee in the amount of 25 percent of the increased permanent disability award for the insurer's allegedly unreasonable failure to pay the compensation awarded in the Order on Reconsideration. On review, the issues are premature closure, offset, and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

The Referee found that claimant was not medically stationary at the time of claim closure on August 29, 1990. Based on the treatment, chart notes and report of Dr. Goby, claimant's treating physician, the Referee concluded that at the time of closure, claimant's back condition was expected to improve with time and medical treatment. We disagree.

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 August 29, 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).

After conducting our review, we conclude that the preponderance of medical evidence establishes that claimant was medically stationary as of July 25, 1990. We base our conclusion on the following reasoning.

Both Dr. Tsai, claimant's operating neurosurgeon, and Dr. Goby agreed that claimant was medically stationary on July 25, 1990. (See Exs. 64, 71). However, in a letter to claimant's attorney dated October 16, 1990, Dr. Goby said the following:

> "This is in follow-up to our recent conversation. [Claimant's] postop medically stationary date would have been on or about July 25, 1990. I do see him as being medically stationary at present but expect him to slowly and gradually improve. That improvement is not expected to be dramatic, however. Please be so informed." (Ex. 71).

Dr. Goby prescribed physical therapy on July 31, 1990, but he also released claimant for modified work at that time, consistent with the limitations imposed by Dr. Tsai at the time he declared claimant to be medically stationary. (See Exs. 65, 2-14, 68-2 and 64). Thus, we interpret Dr. Goby's October 16, 1990 letter to state that although some improvement was to be expected from physical therapy, that improvement was insufficient to alter the July 25, 1990 medically stationary date, at which time claimant's condition was sufficiently stable to allow the extent of his permanent disability to be

assessed. See Alton H. Shotwell, 43 Van Natta 2421, 2422 (1991) (claimant was medically stationary despite physical therapy prescribed); Bobby G. Todd, 42 Van Natta 1648, 1649 (1990). Accordingly, we conclude that claimant has failed to establish that his claim was prematurely closed by the August 29, 1990 Determination Order. Therefore, we reverse the Referee's order on this issue. Claimant did not contest the permanent disability award made by the Order on Reconsideration. Accordingly, we reinstate and affirm the Order on Reconsideration.

Offset

The April 12, 1991 Order on Reconsideration increased claimant's permanent disability award in the amount of $2,880. The insurer did not pay the award, claiming entitlement to an overpayment in the amount of $3,561.57. (See Tr. 2, 8). The Referee declined to authorize an offset, finding that the insurer had failed to establish its entitlement to an offset. We agree.

It is the insurer's burden to prove its entitlement to an offset. Eldon E. Hunt, 42 Van Natta 2751, 2753, (1990); Metro Machinery Rigging v. Tallent, 94 Or App 245 (1988). The Referee found, and we agree, that the evidence is insufficient to support the amount of overpayment the insurer claims. Although the insurer submitted evidence showing that compensation was paid on certain dates (Ex. 75), we are unable to determine how the insurer calculated the claimed overpayment, as there is no claim audit in the record. Cf. Kerrie D. Skinner, 43 Van Natta 394, 399 (1991); Allen L. Frink, 42 Van Natta 2666 (1990).

The insurer contends that it was authorized to take an offset against the permanent disability award made in the Order on Reconsideration, pursuant to the offset authorized in the June 29, 1989 Determination Order. That Determination Order authorized the insurer to deduct overpaid temporary disability from unpaid permanent disability. (Ex. 34). We agree that the authorization continues in effect until it is revoked or until the overpayment is wholly recovered. Berliner v. Weyerhaeuser Company, 92 Or App 264, 268 (1988).

Here, however, we are unable to determine whether the temporary disability overpaid in connection with the 1989 Determination Order was fully recovered. A subsequent Determination Order in August 1990 awarded additional periods of temporary disability, but it did not authorize an offset. (Ex. 68). Moreover, the insurer claims it overpaid not only temporary disability, but also permanent disability compensation. Without an explanation of the purpose of the insurer's payments, or of how it calculated its claimed overpayment, we cannot determine whether any previously authorized offset remains to be recovered. Accordingly, we affirm the Referee's order on this issue and decline to authorize an offset.

Penalty

Because we find that the insurer was not authorized to deduct a claimed overpayment from claimant's permanent disability award of $2,880, as awarded in the April 12, 1991 Order on Reconsideration, we conclude that the insurer unreasonably refused to pay compensation and a penalty is warranted. Accordingly, we affirm the Referee's order assessing a penalty in the amount of 25 percent of $2,880, payable by the insurer, one-half of said amount to claimant and one-half to his attorney.

Since claimant did not submit an appellate brief, he is not entitled to an attorney fee pursuant to ORS 656.382(2). See Shirley M. Brown, 40 Van Natta 879 (1988). Moreover, claimant would not be entitled to an attorney fee on the offset issue, even though he prevailed on that issue. See Strazi v. SAIF, 109 Or App 105 (1991).

ORDER

The Referee's order dated December 10, 1991 is affirmed in part and reversed in part. Those portions of the order which set aside the April 12, 1991 Order on Reconsideration and the August 29, 1990 Determination Order as premature, and that awarded claimant attorney fees out of any increased temporary or permanent disability compensation made payable by the Referee's order are reversed. The August 29, 1990 Determination Order is reinstated. The April 12, 1991 Order on Reconsideration is reinstated and affirmed. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
EILEEN N. FERGUSON, Claimant
WCB Case No. 91-08692
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Richard Pearce, Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of those portions of Referee Daughtry's order which: (1) increased claimant's unscheduled permanent disability award for a low back injury from 21 percent (67.2 degrees), as awarded by an Order on Reconsideration, to 25 percent (80 degrees); and (2) affirmed the Order on Reconsideration to the extent that it awarded no scheduled permanent disability for claimant's alleged loss of use or function of both legs. Additionally, claimant requests that we hold this matter in abeyance pending the final resolution of SAIF v. Herron, 114 Or App 64 (1992). On review, the issues are motion for abeyance and extent of scheduled and unscheduled permanent disability. We deny the motion and affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Motion for Abeyance

Claimant requests that we abate our order and hold this matter in abeyance pending the final resolution of SAIF v. Herron, supra. We deny claimant's request.

We have herein affirmed the Referee's conclusion that claimant is not entitled to an award of scheduled permanent disability. Therefore, the issue of rate of scheduled disability is moot. Moreover, as an adjudicative body, our function is to resolve disputes brought to us by the litigants. In performing these duties, we apply the relevant statutory, administrative, and judicial precedents as they exist at the time of our review. In this way, the litigants are advised in a prompt and orderly manner, and are able to readily determine what further action they wish to take in pursuing their respective remedies. Were we to follow claimant's suggestion and hold this matter in abeyance, resolution of this dispute, as well as numerous others, would be deferred for an indeterminate period awaiting another appellate forum's decision. We do not consider such an action consistent with our statutory role as a decision-maker. See Alfonso S. Alvarado, 43 Van Natta 1303 (1991). We note parenthetically, however, that the Board has approved settlements concerning this issue whereby the parties' agreement is contingent on the final resolution of the Herron case. See e.g. Shirley A. Roth, 43 Van Natta 1802 (1991).

Extent of Permanent Disability

We adopt the Referee's conclusions and reasoning concerning the issues of extent of scheduled and unscheduled permanent disability with the following supplementation.

The sole basis for claimant's objection to the Referee's order is her contention that the temporary standards which were in effect at the time her claim was closed are invalid. Claimant urges the Board to give no effect to those standards, which she contends were adopted in violation of the required rulemaking procedures, and to recalculate the extent of permanent disability under the previous standards. We decline to do as claimant suggests.

ORS 183.400(1) provides:

> "The validity of any rule may be determined upon a petition by any person to the Court of Appeals in the manner provided for review of orders in contested cases. The court shall have jurisdiction to review the validity of the rule whether or not the petitioner has first requested the agency to pass upon the validity of the rule in question, but not when the petitioner is a party to an order or a contested case in with the validity of the rule may be determined by a court. [Emphasis supplied].

In conjunction with this provision, ORS 183.400(2) and (4) provide:

"(2) The validity of any applicable rule may also be determined by a court, upon review of an order in any manner provided by law or pursuant to ORS 183.480 or upon enforcement of such ruled order in the manner provided by law.

(4) The court [on judicial review] shall declare the ruled invalid only if it finds that the rule:

(a) Violates constitutional provisions;

(b) Exceeds the statutory authority of the agency; or

(c) Was adopted without compliance with applicable rule making procedures." [Emphasis supplied].

The emphasized phrases above make it clear that a party may challenge the validity of rule either by direct petition to the Court of Appeals, by petition to the agency which promulgated the rule, or in a contested case proceeding conducted by the promulgating agency. Accordingly, claimant could challenge the validity of the temporary rule at issue by petition to the court or by petition to the Director.[1]

However, 183.400 does not provide authority for one state administrative agency to rule on the validity of another state agency's administrative rules. The Board is not a court, as that phrase is used in ORS 183.400 and we are not the agency that promulgated the rule in question. Therefore, we continue to adhere to our previous position that we have no authority to declare a rule, promulgated by the Director, invalid. See James Frank, 37 Van Natta 1555 (1985); Edward A. Sprague, 38 Van Natta 1441 (1986); Billy Springs, 38 Van Natta 1475 (1986).[2]

Finally, we note that a direct challenge to the validity of the Director's temporary rules is currently pending in the appellate courts. On January 8, 1992, the Court of Appeals dismissed the petitioner's challenge to the validity of the temporary rules as moot on the grounds that the challenged rules have expired, and that to the extent the standards contained in the superceded rules are still applied in certain cases, it is by authority of the currently effective permanent rule, OAR 436-35-003(2). Edmunson v. Dept. of Insurance & Finance (unpublished CA A67544). The Supreme Court allowed the petitioner's petition for review on April 28, 1992 (Supreme Court Case No. S38858). We now turn to the merits.

In evaluating the extent of claimant's permanent disability, the Referee applied the disability standards in effect at the time of the issuance of the Determination Order on December 12, 1990. WCD Admin. Order 6-1988, as amended by WCD Admin. Orders 15-1990 and 20-1990 (temporary rules effective 10/1/90 and 11/20/90); see also, OAR 438-10-010.

Similarly, on review, ORS 656.295(5) directs us to apply "such standards for the evaluation of disability as may be adopted by the director pursuant to ORS 656.726." Accordingly, we limit our consideration to the standards that were adopted by the Director at the relevant time; in this case, at the time of the issuance of the Determination Order on December 12, 1990.

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[1] We note that claimant could have filed a petition with the Court of Appeals, and also requested that the Hearings Division hold further proceedings in the present case in abeyance pending the outcome of the court case. Here, claimant evidently did not file a court petition.

[2] We are bound by the rules promulgated by the Director insofar as they are consistent with the Worker' Compensation Act, and the authority granted the Director by the Act. See Miller v. Employment Division, 290 Or 285 (1980); Charles M. Anderson, 43 Van Natta 463 (1991). However, where there is a conflict between an administrative rule and a substantive provision of ORS Chapter 656, it is the statute rather than the rule which controls. In such circumstances, we apply the statute and give no effect to the rule. Forney v. Western States Plywood, 66 Or App 155 (1983); Walden J. Beebe, 43 Van Natta 2430 (1991). Here, claimant only contends that the Director's rule was invalidly adopted. As explained above, that is a matter outside the purview of this Board.

We find that the Referee applied the appropriate standards in evaluating this claim, and neither party challenges the correctness of the Referee's evaluation under those standards. Accordingly, we affirm the Referee's determination of the extent of claimant's permanent disability.

In light of these circumstances and our statutory directive to apply the standards adopted by the Director, we decline to address claimant's challenge to the validity of the temporary rules. Accordingly, we affirm the Referee's order.

ORDER

The Referee's order dated October 28, 1991, is affirmed.

Board Member Hooton dissenting.

In this case we have been specifically requested to review the validity of the temporary rules for the evaluation of permanent disability adopted by the Department following passage of SB 1197. The majority concludes that we lack that authority because it is reserved to the "agency" which adopted the rule, or to the courts under ORS 183.400. The majority concludes that we are not the agency, neither are we a court as that term is used in ORS 183.400. While I agree that the Workers' Compensation Board is not a court within the meaning of ORS 183.400, I would conclude that the Workers' Compensation Board is the "agency" for purposes of the determination of the validity of the present rules.

Because of frequent changes, both major and minor, it is often difficult to remember where we have come from in the Workers' Compensation Law, let alone use that history as guidance in the appropriate case. Here, however, it is difficult to determine the relationship that exists between the Workers' Compensation Division of the Department of Insurance and Finance and the Workers' Compensation Board without an awareness of the development of that relationship over time. Consequently, to assist in the determination whether the Board has authority to review and invalidate rules promulgated by the Division, I begin with the passage of the Workers' Compensation Law in 1913.

The original version of the Workers' Compensation Law created the State Industrial Accident Commission. That Commission was comprised of three members appointed for four year terms. The original terms of appointment expired in 1915, 1916 and 1917 with succeeding appointments to last for four years. In recognition of the political interests involved in workers' compensation generally, no more than two of the commissioners were to be appointed from a single political party and the commissioners were appointed to represent the interests of labor, employers and the public respectively. §6606 Oregon Laws (1920). The most cursory comparison of §6606 Oregon Laws (1920) with current ORS 656.712 is sufficient to establish that the history of the current Board began with the creation of the State Industrial Accident Commission some 79 years ago.

The powers of the State Industrial Accident Commission were vast indeed. It not only acted as the administrative body responsible for promulgating rules and procedures for the administration of the Workmen's Compensation Law, it also administered the Industrial Accident Fund and generally undertook all of those actions appropriate to an insurer. §§6612, 6632 & 6633 Oregon Laws (1920).

In addition, the Commission took initial responsibility for determining the respective rights of the parties in the resolution of disputes. The Commission had no authority to hold hearings in contested cases following passage of the Workmen's Compensation Law in 1913 . That deficiency, however, was remedied by amendment in 1917. See Keith Skelton, The 1965 Oregon Workmen's Compensation Law: A New Model for the States, 45 OLR 40,55 (1965). Hearings, however, generally included only the claimant who contested the determination of the Commission before the Commission itself. To provide an impartial forum for review of that decision claimant was entitled to Circuit Court review with a full trial to a jury. §6637 Oregon Laws (1920). Consequently, Oregon's original workers' compensation agency was unitary in appearance and in fact with Circuit Court enforcement and review as anticipated under ORS 183.400(2).

The Workmen's Compensation Law continued from 1913 to 1925 without significant change in

its administrative appearance, though there were some modifications in entitlement.[1] In 1925, however, the act was amended to require rehearing before the commission as a prerequisite to Circuit Court jurisdiction, and the review function of the current Workers' Compensation Board was born. §49-1842 Oregon Code Annotated (1930). The worker retained his right to Circuit Court review with a full trial to a jury upon completion of the rehearing. §49-1843 Oregon Code Annotated (1930).

With the addition of the requirement for rehearing the administrative structure of the Commission remained essentially unchanged until 1965. See for example ORS 656.272 to 656.294 and 656.402 to 656.428 (1963).

In 1965 the legislature adopted what were then considered sweeping changes to the Workmen's Compensation Law. The Law was made compulsory for all employers and the system was expanded from its single faceted delivery system with the State, through the Commission, acting as the insurer, to a dual system that permitted both contributing and direct responsibility employers. ORS 656.016 (1965). In order to facilitate the inclusion and regulation of direct responsibility employers, the regulatory functions of the agency were separated from the insurance functions. The Commission was renamed the Workmen's Compensation Board and the legislature created the State Compensation Department. However, the unitary nature of the administration of the Workmen's Compensation Law remained intact. The Board retained all administrative and regulatory functions, as well has the authority to conduct hearings and review. ORS 656.726 (1965) The Department was granted authority appropriate to its function as the insurer for contributing employers.[2] ORS 656.752 (1965). In its role as an insurer, all of the Department's functions were properly subject to review by the Board.

Claimants retained a right to hearing and Board Review, and to a trial before the Circuit Court, though that trial no longer included the right to a jury. ORS 656.283, 295 and 298 (1965).

The next major revision to the administrative structure of the Workmen's Compensation Law occurred in 1977.[3] The major focus of the legislative changes at that time was the loss of Circuit Court review in any form. See ORS 656.298 (1977). The loss of what had been for 64 years the only truly impartial forum for a hearing in Workmen's Compensation matters engendered considerable debate and political compromise. As a part of that compromise the Workers' Compensation Department was created. ORS 656.708 (1977).

The Workers' Compensation Department was comprised of interdependant but independent bodies working together to complete the purpose of the Workers' Compensation Law as a single agency or Department. The Department was comprised of the Worker's Compensation Board and the Director. ORS 656.708(1) (1977). The Board retained authority over all matters concerning injuries prior to 1965 and provided the agency's dispute resolution forum for matters concerning a claim for all claims arising after 1965. The Hearings Division was expressly continued under the authority of the Board and was, in light of the political compromise, given the express duty of "providing an impartial forum for deciding all cases, disputes and controversies arising under ORS 654.001 to 654.295 and 656.001 to 656.794, and for conducting such other hearings and proceedings as may be prescribed by law." ORS 656.708(3) (Emphasis added.) The effect of the changes in 1977 was to replace the function of the Circuit Court in the review process of agency decisions with an informal hearing before an administrative body which

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[1] One amendment to the Workmen's Compensation Law that still has special significance today occurred in 1919 when §6641 was adopted and became effective on January 17, 1920. That section provides in pertinent part as follows:

> "provisions [of the Workmen's Compensation Act] shall be liberally construed for the purpose of carrying out the intent of this statute, which is to provide additional compensation to injured workmen , their dependents and beneficiaries, for the period of time expressed in this act."

[2] The State Compensation Department was shortlived in name only. In 1969 the legislature renamed the State Compensation Department to its present State Industrial Accident Fund but otherwise left unchanged the nature of the division of authority between the Board and the State's insurance company.

[3] One of the changes which occurred in 1977 was the renaming of the Law itself. The term Workmen's Compensation Law was modified to its present form as the Workers' Compensation Law. Department, Board and Division names have followed suit accordingly.

was a part of the agency yet insulated from influence by the rulemaking, or regulatory, component of the agency. This unique development in the area of administrative law espands the notion of "agency" to include an administrative system incorporating the principles of check and balance that are a model of state and federal governmental structure throughout the United States.

Incorporation of the principles of check and balance into the agency structure for administrative agencies presents significant opportunities and advantages. The agency as a whole is less susceptible to the potential for agency capture, a situation which can develop where the regulating agency adopts a protective stance toward the industry regulated. Occurrences of agency capture are not infrequent since, despite the provision for public hearing in rulemaking procedures, an occurrence notably absent in the adoption of temporary rules, the parties appearing most often before the agency, and whose views are most widely known, are, in fact those of the regulated industry.[4]

In addition, the opportunity for every interested party, including claimants, who appear infrequently and express their views most often in a contested proceeding, to regularly influence the overall operation of the agency permits the development of the administrative law to meet changing circumstances and to incorporate new methods without the need for constant legislative intervention. Because of the check and balance system, the agency has all of the tools necessary to produce that "fair and just administrative system" that is the purpose of the Workers' Compensation Law. ORS 656.012(2)(a).

To take advantage of the possibilities inherent in the check and balance structural format, however, two things need to occur. The adjudicatory body must be sufficiently strong to assert and defend its jurisdiction over the acts of the regulatory body. In like manner the regulatory body must accept the oversight of the adjudicatory body, either willingly, or with the assistance of the Appellate Courts. Only in the adaptation of the regulatory body to decisions of the adjudicatory body can a strong and "fair" administrative system emerge.

Since 1977 there have been only two significant modifications to the administrative structure of the Workers' Compensation Law. In 1979 the Workers' Compensation Board lost authority over vocational rehabilitation when the Field Services Division was created and placed under the authority of the Director. ORS 656.710 (1979). In 1981 the system itself expanded into a three way insurance system including private insurers together with the State Industrial Accident Fund and direct responsibility, or self insured employers. ORS 656.017 (1981).

If one follows only Chapter 656 it would appear that a subsequent and potentially significant change occurred in 1985. In that year any reference to the Workers' Compensation Department and its composition is removed from ORS 656.708 and does not again return to the statute. The division of responsibility remains in ORS 656.726, however, and a further examination of statute indicates the nature of the actual changes that occurred at that time.

In 1985 the Department of Insurance and Finance was created and the responsibilities of several agencies previously in existence were transferred to that agency. Among them were the Workers' Compensation Department and the Workers' Compensation Board. See ORS 705.105 (1985). The nature of the relationship between the Workers' Compensation Division of the Department of Insurance and Finance, and the Workers' Compensation Board, however, did not change. These two bodies work together to form the agency responsible for regulation and adjudication under the Workers' Compensation Law. The Division has the same regulatory and administrative authority as the Director

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[4] The fear of agency capture probably informed most of the political debate surrounding the loss of Circuit Court review. The fear of biased or partial rulemaking has subsequently been confirmed, at least, with the adoption of SB 1197 as evidenced in the very rules whose validity are challenged in the present proceeding. With the passage of SB 1197 the Department rushed to issue temporary rules, modifying the Standards then in existence to implement the Departments restrictive definition of objective findings and applying that definition to the determination of disability. Since that time the definition of "objective findings" has been considered by this Board and the Court of Appeals. Suzanne Robertson, 43 Van Natta 1505 (1991); Georgia-Pacific Corp. v. Ferrer, 114 Or App 471 (1992). The definition of that term that is currently applicable is vastly different from the Department's original conception. However, there has been no similar rush to enact new standards that reflect the current state of the law. Such standards would necessarily be considerably more favorable to claimants than the current version.

in the pre-1985 Workers' Compensation Department. The Board retains adjudicatory and review authority on matters concerning a claim. The check and balance of independent bodies in a unitary agency structure is preserved.

Based on the above history I would conclude that there is a linear review function between the Department through the Workers' Compensation Division and the Workers' Compensation Board. The Division promulgates those rules reasonably necessary to accomplish the administration of the act. The Division, however, is not empowered to enforce those rules on matters concerning a claim. That function is reserved solely to the Workers' Compensation Board. ORS 656.704 and 656.726. Nevertheless, the interlocking but independent exercise of authority by each of the respective elements of the "administrative system" does not mean that there is more than one "agency" involved. As the term "agency" is intended under the provision of the Administrative Procedures Act, the Workers' Compensation Board is an integral element of the "agency" whose responsibility is the administration of the Workers' Compensation Law. Because we are an element of that agency, and, in fact, the element charged with responsibility for the enforcement of the administrative rules, we have authority, and indeed the duty, to determine the validity of rules bearing on matters concerning a claim.[5]

By declining to assert and staunchly defend our authority, we not only deprive this claimant of the review the statute intended, we also weaken the very structure of this unique administrative system, limiting its effectiveness and preventing a final resolution of the many shared jurisdictional questions that arise under the 1990 amendments to the Workers' Compensation Law. That outcome is detrimental to all parties concerned. Therefore, I dissent.

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[5] There is absolutely no doubt that the Workers' Compensation Board is the administrative body charged with the enforcement of those administrative rules that bear on matters concerning a claim. It would be most unusual if the Board had the authority to declare the laws adopted by a duly elected legislature unconstitutional, but could not question the validity of rules adopted administratively, a therefore without the legitimacy added by the electoral process, within its own agency system. See for example, Nutbrown v. Munn, 311 Or 328, 346 (1991).

In the Matter of the Compensation of
JANELLE R. FOOTE, Claimant
WCB Case No. 90-12597
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of that portion of Referee Tenenbaum's order that set aside its denial of claimant's occupational disease claim for post-traumatic stress syndrome. Claimant cross-requests review of that portion of the Referee's order that allowed a medical report into evidence. Additionally, claimant contends that the insurer's request for review should be dismissed for failure to comply with OAR 438-11-005(4). On review, the issues are motion to dismiss, evidence and compensability. We deny the motion to dismiss and affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Motion to Dismiss

Claimant contends that the insurer's request for review should be dismissed because it does not recite whether payment of compensation will be stayed under ORS 656.313 pending review of the the Referee's order. In support of this contention, claimant relies on OAR 438-11-005(4). We have

previously held that OAR 438-11-005(4) is not jurisdictional, but rather, is an informational aid, designed to assist the Board in identifying cases subject to expedited review under ORS 656.313(1)(b). See Leslie Thomas, 43 Van Natta 1364, 1365. Accordingly, we deny claimant's motion.[1]

Evidence

Claimant contends that the Referee erred in allowing reports and testimony from Dr. Parvaresh into the record. In support of this contention, claimant argues that Dr. Parvaresh relied on documents concerning claimant's son that were obtained in violation of federal law. We disagree.

Referees are not bound by common law or statutory rules of evidence or by technical or formal rules of procedure and may conduct the hearing in any manner that will achieve substantial justice. ORS 656.283(7); Armstrong v. SAIF, 67 Or App 498 (1984). We review the Referee's evidentiary rulings for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991).

The documents concerning claimant's son's treatment were not submitted as evidence. Rather, claimant's objection concerns Dr. Parvaresh's indirect reference to those documents when discussing claimant's condition. Moreover, the documents concern claimant's son and not claimant. Under these circumstances, we conclude that the Referee did not abuse her discretion in admitting Dr. Parvaresh's reports and testimony.

Compensability

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

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 is $1,500, 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 statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated December 18, 1991 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,500, payable by the insurer.

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1 Although a signatory to this order, I do not agree that the employer's failure to request expedited review is not subject to some penalty for failure to follow OAR 438-11-005(4). If we are not going to enforce this rule, why have it?

In the Matter of the Compensation of
MICHAEL K. JANES, Claimant
WCB Case Nos. 91-06087 & 90-22446
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Hallock & Bennett, Defense Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer, Loy Clark Pipeline, requests review of that portion of Referee Menashe's order that set aside its denial of claimant's current condition claim for a low back condition and claimant's aggravation claim for the same condition. On review, the issues are compensability of the current condition and aggravation.

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

We agree with the Referee that the reports and deposition of Dr. Beck, treating physician, establish that the November 1985 work injury is the major contributing cause of claimant's current condition. (Exs. 62, 67, pages 20-22, 41-44, 46-48). We further agree with the Referee that the record establishes a compensable aggravation. We write only to supplement his opinion regarding arguments made by the employer that claimant had established neither a compensable worsening nor a diminished earning capacity.

The employer argues that we should rely on the opinion of Dr. Apple, former treating chiropractor, who opined that there was no worsening of claimant's condition. (Exs. 65-1, 66). We disagree. Dr. Apple treated claimant before and after the compensable November 1985 injury. However, there is no evidence that he treated claimant during or after the period in which claimant's condition caused Dr. Beck to find that he was unable to work. Also, there is no evidence that Dr. Apple reviewed the February 1991 MRI. Furthermore, although Dr. Beck did not treat claimant at the time of the initial claim closure, he compared the medical reports of that period with claimant's condition when Dr. Beck began treating him and presented a well-reasoned analysis that claimant's condition had worsened. (Ex. 62-1, -2). This is in contrast to Dr. Apple's conclusory statement that there had been no worsening. On these bases, we conclude that the Referee was correct in deferring to Dr. Beck's opinion that claimant's condition had worsened.

The employer also argues that claimant has not proved a diminished earning capacity. In support of this argument, the employer asserts that: (1) claimant is currently released to all but heavy construction work which is the same limitation placed on him at the last arrangement of compensation; and (2) claimant was not earning any wages at the time of the last arrangement of compensation and he is currently not earning any wages. We do not find these assertions persuasive.

Regarding the first assertion, we disagree with the employer's characterization of claimant's current release to work. In a June 1991 report, Dr. Beck opined that claimant was unable to work and foresaw that he would never be able to return to more than light work with restrictions. (Ex. 62-4). Dr. Beck predicted that claimant might be able to perform this light work with restrictions within two to three months. Id. We do not find that Dr. Beck retracted these limitations during his August 1991 deposition. (Ex. 67-40). More importantly, claimant's current ability to work is not relevant to the issue of whether a compensable aggravation has been established because diminished earning capacity is determined at the time of the alleged aggravation. Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Here, in October 1990, Dr. Beck found that claimant was unable to work due to his worsened condition.

As to the employer's second assertion, claimant need not prove an actual loss of wages to establish a compensable aggravation. Claimant need only prove that, because of the worsening, he was less able to work in that he was "temporarily incapacitated from regularly performing work at a gainful and suitable occupation." International Paper Co. v. Hubbard, 109 Or App 452, 455 (1991), citing Smith v. SAIF, 302 Or 396, 401 (1986). Dr. Beck's release from work establishes that claimant sustained a diminished earning capacity due to the worsening.

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 issues of compensability and aggravation is $1,200, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated November 21, 1991, as corrected on December 2, 1991 and December 11, 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.

In the Matter of the Compensation of
KEVIN M. KIRKPATRICK, Claimant
WCB Case No. 91-03746
ORDER ON REVIEW
Max Rae, Claimant Attorney
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Spangler's order that: (1) declined to reclassify claimant's October, 1986 mid-back injury claim; (2) upheld the insurer's denial of claimant's aggravation claim for a worsened mid-back condition; (3) declined to award temporary disability compensation for the period from January 21, 1991 through March 7, 1991; and (4) declined to assess a penalty or related attorney fee for the insurer's allegedly unreasonable claims processing. On review, the issues are claim classification, aggravation, temporary disability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We agree with the Referee's determination that the 1990 amendments to Worker's Compensation Act apply to claimant's request for claim reclassification and we adopt his reasoning in this regard.

Claim Classification

The Referee declined to reclassify claimant's claim. We agree, based on the following reasoning.

ORS 656.277(2) and ORS 656.273(4)(b) both provide that if a claim that a nondisabling injury has become disabling is made more than a year after the date of injury, the claim shall be made as an aggravation pursuant to ORS 656.273. After expiration of the one year period, a reclassification request is made as an aggravation claim under ORS 656.273. See Gregory S. Myers, 44 Van Natta 1759 (1992). Corinne K. Freeman, 44 Van Natta 495 (1992).

Here, claimant did not seek reclassification of his October 1986 mid-back injury claim until December, 1990. (See Ex. 28A). Because more than one year passed between the injury and the request for reclassification, the current claim must be treated as a claim for aggravation under ORS 656.273. Myers, supra.

In reaching this conclusion, we necessarily reject claimant's contention that the Referee's authority depends on whether the claim was originally misclassified. After the amendments to ORS 656.273(4)(b), and the addition of ORS 656.277, there is no longer a distinction between an injury that was initially misclassified as nondisabling and an injury which was nondisabling but which has become disabling. After the passage of one year, both claims must be made as aggravation claims. See ORS 656.277; ORS 656.273(4)(b). As we have previously noted, the "new law" effectively eliminated the rationale behind Davison v. SAIF, 80 Or App 541 modified on recon 82 Or App 546 (1986). See Gregory S. Myers, supra; Oliver M. Payton, 43 Van Natta 2738, 2739 (1991).

Aggravation/Temporary Disability Benefits

We adopt those portions of the Referee's conclusions entitled "Aggravation" and "Temporary Disability."

Penalties and Attorney Fees

We adopt the Referee's conclusions concerning the penalty issue with the following supplementation.

We agree with the Referee's conclusion that no penalty may be awarded because there are no "amounts then due" in this case. Moreover, because claimant has not proven a compensable aggravation claim, no attorney fee may be awarded under ORS 656.382. See Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991); see also Boehr v. Mid-Willamette Valley Food, 109 Or App 292, 295 (1991).

ORDER

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

September 21, 1992 Cite as 44 Van Natta 1820 (1992)

In the Matter of the Compensation of
MINDI M. MILLER, Claimant
WCB Case No. 91-03072
ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
Schultz & Taylor, Defense Attorneys

The insurer requests reconsideration of our August 24, 1992 Order on Review. Specifically, the insurer notes that our order did not address the issue of temporary disability benefits, an issue it raised in its cross-request for Board review.

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

IT IS SO ORDERED.

September 21, 1992 Cite as 44 Van Natta 1820 (1992)

In the Matter of the Compensation of
NELLDA J. MORRIS, Claimant
WCB Case No. 91-15691
ORDER WITHDRAWING ORDER OF DISMISSAL
Cummins, et al., Defense Attorneys

On August 27, 1992, we withdrew our August 14, 1992 Order of Dismissal in which we dismissed claimant's request for Board review of the Referee's June 18, 1992 order. In dismissing claimant's request for review, we had found that claimant had not established that she had timely notified the other parties to the proceeding of her appeal. We withdrew our dismissal order to consider claimant's affidavit, which stated that she mailed copies of her request for Board review to the employer, its insurer, and its attorney on July 17, 1992 (within 30 days of the Referee's June 18, 1992 order). We also granted the insurer an opportunity to respond. Having received that response, we proceed with our reconsideration.

The insurer contends that claimant has failed to establish that she mailed copies of her request for review to the other parties within 30 days of the Referee's order. We agree with the insurer that claimant's submission of copies of unpostmarked envelopes addressed to the employer, its insurer, and legal counsel do not satisfy the statutory notice requirements of ORS 656.289(3) and 656.295(2).

Nevertheless, claimant has also forwarded her affidavit, swearing that she mailed copies of her request for Board review in postpaid envelopes to the employer, its insurer, and their legal counsel on July 17, 1992. Except for the insurer's objection to the probative value of the copies of unpostmarked envelopes, claimant's sworn statement of timely mailing is otherwise unrebutted.

Under such circumstances, we find that claimant has established that she mailed copies of her request for Board review to the other parties within 30 days of the Referee's June 18, 1992 order.

Consequently, we hold that timely notice of her appeal was provided to the other parties and that we retain jurisdiction to consider this matter. See ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, 63 Or App 847 (1983); Franklin Jefferson, 42 Van Natta 509 (1990); Greg Carpenter, 40 Van Natta 100, 349 (1988).

In reaching this conclusion, we distinguish this case from Lyle J. Johnson, 44 Van Natta 1216 (1992). In Johnson, we dismissed a request for Board review as untimely. In disputing our dismissal, claimant submitted an unsworn statement that he had mailed his request to the Board with a copy to the insurer on a date within 30 days of the Referee's order. In response, the insurer contested both assertions, stating that it did not receive a copy of claimant's request until a month after he claimed he had mailed it. Reasoning that claimant's statements were not contained in an affidavit (putting aside questions raised by the insurer's response), we concluded that claimant had failed to rebut the presumption of untimeliness as set forth in OAR 438-05-046(1)(b).

Here, in contrast to Johnson, claimant has submitted an affidavit, attesting to the fact that she mailed copies of her request to the other parties in a timely manner. Moreover, other than questioning the persuasiveness of the unpostmarked envelopes, the insurer has not claimed that it did not receive copies of the request that claimant swears she mailed on July 17, 1992. Such circumstances establish to our satisfaction that claimant timely mailed copies of her request for review to the other parties. Therefore, we retain jurisdiction to consider claimant's appeal.

Accordingly, we withdraw our dismissal order. A hearing transcript has been ordered. Upon its receipt, copies will be distributed to the parties and a briefing schedule implemented. Following completion of the briefing schedule, this case will be docketed for Board review.

IT IS SO ORDERED.

In the Matter of the Compensation of
KENNETH L. ORR, Claimant
WCB Case No. 91-04825
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Nichols' order which upheld the insurer's "back-up" denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. Claimant contends that the insurer should be held to its acceptance, by stipulation, of claimant's occupational disease claim. Claimant further asserts that the parol evidence rule bars extrinsic evidence of the parties' prior negotiations and oral agreements. The insurer argues that its acceptance was due to a drafting error and that it should not be held to the stipulation, or, in the alternative, that it issued a valid "back-up" denial of the claim pursuant to ORS 656.262(6). On review, the issues are the applicability of the parol evidence rule and the propriety of the insurer's "back-up" denial. We affirm.

FINDINGS OF FACT

On August 20, 1987, claimant sustained a compensable injury to the low back and pelvis for which he has received a total of 41 percent unscheduled permanent disability.

A September 7, 1990 medical report from Dr. Tsai mentioned that claimant had a new finding on examination which was indicative of early carpal tunnel syndrome. On September 24, 1990, the insurer issued a partial denial of claimant's carpal tunnel syndrome. The insurer denied the carpal tunnel syndrome on the basis that it was unrelated to claimant's August 1987 injury. (Ex. 65). Claimant filed a request for hearing on the denial. (Ex. 65A).

Claimant's attorney subsequently contacted the insurer's claims examiner and told her he thought the denial was premature since no claim for carpal tunnel syndrome had yet been made. (Tr. 38-39). Claimant's attorney and the insurer's claims examiner reached an agreement that the insurer would withdraw its denial of claimant's carpal tunnel syndrome and would "go back to square one." The insurer would then process the claim to acceptance or denial. The parties decided to enter into a stipulation to this effect. (Tr. 41). There was no agreement between the parties that the carpal tunnel syndrome condition would be accepted.

On January 9, 1991, claimant advised the insurer that he was filing an occupational disease claim for carpal tunnel syndrome. (Exs. 69A). The insurer's claims examiner directed a legal assistant to draft a stipulation which withdrew the insurer's denial and assigned a new claim number to the carpal tunnel claim. The agreement was not to contain a provision accepting the claim. (Tr. 62). When drafting the stipulation, the legal assistant mistakenly drafted the document stating that the carpal tunnel claim would be "accepted as a separate claim with a separate claim number." The claims examiner "scanned" the document but did not discover the drafting error until after it had been signed by the parties and approved by a referee on February 11, 1991. (Ex. 73A).

After discovering the error, the claims examiner sought advice from the insurer's in-house attorney. The insurer's claims examiner asked the in-house attorney to contact claimant's attorney and ask that the stipulation be amended to reflect the parties' agreement. The insurer's attorney contacted claimant's attorney by phone and asked for consent to amend the stipulation. Claimant's attorney asked the insurer's attorney to draft a letter requesting that the stipulation be amended and providing that claimant's attorney would leave the decision up to his client (the claimant in this matter).

On February 21, 1991, the insurer's attorney wrote to claimant's attorney stating in part:

> " * * * Per your request, this letter will request that your client allow for the submission of an Amended Stipulated settlement and Order of Dismissal.
>
> "The basis of this request is the use of the word accepted in settlement provision #1. Based on my conversation with you and discussions I have had with the claims examiner, your intent through this Stipulation was to remove the right carpal tunnel syndrome claim from claimant's accepted August 20, 1987 injury claim. Your position was that no claim had yet been made upon which to base the partial denial. The settlement was drafted so that the partial denial could be withdrawn and the carpal tunnel claim, if made, could be processed as a separate claim with a separate claim number. Nothing was said about either accepting or denying the claim, <u>which had not yet been made</u>. Unfortunately, as we discussed, the term <u>accepted</u> has a meaning in workers' compensation law which may allow this claim to proceed contrary to the negotiations behind the document * * *" (Ex. 74A). (Emphasis in original).

Claimant's attorney responded in a letter dated March 8, 1991. It states in part:

> "* * * My client has instructed me that I should take advantage of whatever legal effect of the Stipulated Settlement & Order of Dismissal, signed February 11, 1991, may have on his separate carpal tunnel syndrome claim.
>
> "[Claimant] has indicated in our conversation that he feels that you folks have played 'hard ball' with him, since he originally had a claim for asthma and the claim referenced above. [Claimant] does not feel that he owes you any good grace * * *" (Ex. 74B).

The insurer denied the carpal tunnel claim on April 1, 1991. On July 12, 1991, the insurer issued a "back-up" denial of its stipulated acceptance of the carpal tunnel claim.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the insurer had proven by clear and convincing evidence that the carpal tunnel syndrome was not compensable and upheld the insurer's July 1991 "back-up" denial. The

Referee also found that the carpal tunnel claim had been accepted by mistake, in that the stipulation, which used the term "accepted," did not reflect the actual intent and agreement of the parties. In reaching this conclusion, the Referee relied on extrinsic evidence of the parties' negotiations and prior oral agreement. We affirm, but for the following reason. We conclude that the stipulation, which does not reflect the true agreement of the parties, does not constitute an acceptance of the claim and should not be enforced.

ORS 656.283(7) provides in part: "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 evidence in this case shows that the parties reached an agreement to withdraw the prematurely issued partial denial of the carpal tunnel syndrome and process the claim to acceptance or denial. However, due to a drafting error, the written agreement indicated that the carpal tunnel condition would be accepted.

The issue here is whether evidence of the parties' negotiations and intent is admissible to interpret the stipulation. We find that in the instant case it does not serve the interests of substantial justice to apply the parol evidence rule to uphold an agreement which so obviously does not reflect the parties' bargain. We have regarded vacating prior stipulated 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). We find this to be an extreme situation where in the interests of substantial justice the stipulation should not be enforced as written, but should be interpreted according to the parties' mutual intent.

Accordingly, we hold that the Referee acted within her discretion in allowing parol evidence of the parties' actual agreement and we interpret the stipulation consistent with the intent of the parties. Because we interpret the contract in accordance with the parties' intended agreement, and not as an acceptance of the carpal tunnel claim, we address the merits of the April 1, 1991 denial.

In order to establish an occupational disease, claimant has the burden to prove, by medical evidence, supported by objective findings, that his employment conditions were the major contributing cause of his carpal tunnel syndrome. ORS 656.266; 656.802.

The causation of claimant's carpal tunnel syndrome is a complex medical question which must be resolved by expert medical evidence. See Uris v. Compensation Department, 247 Or 420, 426 (1967).

No physician relates claimant's carpal tunnel syndrome to his employment conditions. Dr. Button examined claimant and opined that claimant's carpal tunnel syndrome was not related to his employment, but rather was idiopathic in nature. Dr. Buza and Dr. Tsai, both treating physicians, concurred with Dr. Button's report. Accordingly, we find that claimant has failed to establish a compensable occupational disease.

Assuming, arguendo, that parol evidence should not be considered and that we are required, notwithstanding the parties' actual intentions, to treat the stipulation as an acceptance, we would uphold the insurer's "back-up" denial. In Susie A. Fimbres, 44 Van Natta 1730 (1992), we rejected the argument made by claimant here that ORS 656.262(6) is not applicable to a stipulated claim acceptance.[1] Furthermore, we find no reason in the record to conclude that the insurer did not act in "good faith" when it purportedly accepted the claim by executing the stipulation in question. Therefore, we would conclude that the insurer accepted the claim in "good faith" within the meaning of ORS 656.262(6).

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[1] Although a signatory to the present order, Board Member Gunn directs the parties' attention to his dissenting opinion in Susie A. Fimbres, supra.

Finally, as discussed above, no physician related claimant's carpal tunnel syndrome to his employment conditions. Therefore, if the burden was on the insurer to prove by clear and convincing evidence that the claim is not compensable, the insurer clearly carried its burden.

ORDER

The Referee's order dated August 9, 1991 is affirmed.

In the Matter of the Compensation of
BRENDA K. PASSMORE, Claimant
WCB Case No. 91-09064
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Myers' order that upheld the insurer's partial denial of claimant's mental disorder 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's psychological condition was not compensable, because the medical evidence did not establish that the July 1988 compensable injury was the major contributing cause of the disability and need for treatment. We agree with the Referee's conclusion, but offer the following analysis.

Claimant is asserting the compensability of her psychological condition as a consequence of her compensable neck injury. Because claimant alleges the condition is a "consequence" of the injuries sustained in the industrial accident, claimant has the burden to prove that the compensable injury is the major contributing cause of the consequential condition. ORS 656.007(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). We find the causation of claimant's psychological condition to be a complex medical question, the resolution of which requires expert medical evidence. Uris v. Compensation Dept, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Two expert opinions were submitted in this matter. Dr. Holland, a psychiatrist, examined claimant on September 6, 1991, After a review of the extensive medical record and examination, Holland concluded that claimant's personality disorders had been present throughout her adult life and that the industrial injury did not play a major role in claimant's need for psychiatric treatment. He based his opinion on the fact that claimant had experienced numerous off-work psychosocial stressors which he believed played a much more significant role in claimant's condition than her industrial injury. The other opinion comes from Dr. McQueen, the treating psychologist, who disagreed with Holland. McQueen did not specifically address the causal relationship between claimant's personality disorder and the industrial injury, but stated: "It is not sensible to imply that the preexisting somatization syndrome means that [claimant] has not experienced harmful sequelae to industrial injury." (Ex. 64-1).

When there is a dispute between medical experts, we give greater weight to those opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). We find the opinion of Holland most persuasive. He provided a detailed and well-reasoned opinion, in which he logically discussed the interplay of claimant's multiple nonwork stressors and her psychological disorder. Moreover, his assessment of the role that these offwork stressors played in the exacerbation of claimant's personality disorder is consistent with her medical and family history. We

give less weight to the opinion of McQueen, because her analysis regarding causation was conclusory and without explanation.

After our review, we conclude that claimant has failed to establish that the 1988 compensable injury is the major contributing cause of her psychological disorder. Accordingly, we conclude that claimant has failed to establish the compensability of the consequential condition and uphold the insurer's denial.

ORDER

The Referee's order dated January 8, 1992 is affirmed.

In the Matter of the Compensation of
PATRICIA D. SIMMONS, Claimant
WCB Case No. 91-10944
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Leahy'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 vacate.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The insurer contends that claimant is precluded from challenging the $125 rate at which her permanent disability award was paid pursuant to a July 25, 1990 Determination Order. We agree.

Claimant timely requested a hearing challenging the Determination Order, raising the issues of closure date and extent of disability, but not rate of payment of the scheduled permanent disability award. The earlier Referee affirmed the Determination Order. Claimant requested review by the Board, but again she did not challenge the rate of payment of the award. We issued our Order on Review on February 27, 1992, affirming that portion of the Referee's order which affirmed the Determination Order. Our Order on Review was not appealed, and the Determination Order became final by operation of law.

Subsequent to the present Referee's order, we held that because objection to a Determination Order is not limited to extent of disability issues but also concerns the amount of compensation awarded, objection to the rate of compensation must be made by challenging the Determination Order. The rate issue arises directly from the scheduled permanent disability awarded by the Determination Order. See Charlene J. Erspamer, 44 Van Natta 1214 (1992).

Here, claimant timely challenged the Determination Order, but in that proceeding she never objected to the rate of payment of the award. The Determination Order awarded a specific dollar amount of scheduled permanent disability, and subsequent orders affirmed the award. Cf. Lester M. Gibson, 44 Van Natta 1260 (1992) (referee replaced Determination Order award with percentage of disability; therefore, rate of payment of the award remained viable issue). The Determination Order is now final by operation of law. Accordingly, claimant is precluded from challenging the $125 rate at which her permanent disability award was paid.

Claimant filed a separate request for hearing on August 14, 1991, raising the sole issue of rate of payment of the scheduled permanent disability award under the July 25, 1990 Determination Order.

However, this request for hearing was not timely, coming more than 180 days after the issuance of the Determination Order. Former ORS 656.268(6). Therefore, the Referee lacked jurisdiction to consider the hearing request.

Accordingly, since the Referee lacked jurisdiction to consider the rate of payment of the scheduled disability award, we vacate the Referee's order and dismiss claimant's request for hearing.

ORDER

The Referee's order dated December 23, 1991, as corrected January 23, 1992, is vacated. Claimant's request for hearing is dismissed.

In the Matter of the Compensation of
GLEN I. WEBBER, Claimant
WCB Case No. 91-10402
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee McWilliams' order that: (1) upheld the self-insured employer's partial denial of claimant's claim for a mental disorder; and (2) denied claimant's request to assess a penalty for the employer's allegedly unreasonable denial. On review, the issues are compensability and penalties. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's mental disorder, which she analyzed as a "consequence of a compensable injury" under ORS 656.005(7)(a)(A), was not compensable because claimant had failed to establish that the industrial injury was the major contributing cause of his need for medical treatment. We agree and adopt the Referee's conclusions and reasoning. We add the following supplementation.

In concluding that the mental disorder was not compensable, the Referee rejected the opinion of Dr. Brown, the treating psychiatrist, because he failed to offer any explanation for his change in opinion regarding causation. On review, claimant attempts to provide an explanation by suggesting that Dr. Brown's first opinion addressed only a portion of the industrial injury, while his later opinion addressed the industrial injury as a whole. It explains:

> "In that report dated June 14, 1991, Dr. Brown stated: 'Whether the blow [claimant] received to his head in his fall at work had anything to do with the problems he presented cannot be determined by this examiner.' Dr. Brown's later opinion addresses the whole industrial injury and its sequelae, including the debilitating back and neck pain, not just one component." (Emphasis and citations omitted.)

After our review of the record, we are not persuaded by claimant's attempt to reconcile the two opinions. Dr. Brown first treated claimant in March 1991, some nine months after the compensable injury. By the time he had rendered his first opinion, he had treated claimant for approximately three months, during which he had discussed the relationship between the injury and the disorder on numerous occasions. As a result, there is no reason to believe that Dr. Brown lacked full knowledge of the extent of the industrial injury. Furthermore, as noted by the employer, Dr. Brown specifically stated in his June 14 report that it was his opinion that "the condition I treated pre-existed his industrial

injury." (Ex. 17-2). While he subsequently referred to the possible effect the blow to claimant's head may have had on his disorder, his opinion, when read as a whole, does not support the conclusion that he intended to exclude all other physical injuries claimant suffered in the compensable injury.

Claimant also contends that, even if the compensable injury is not the major contributing cause of his need for medical services, the employer's denial must be set aside because "treatment of the depression is necessary to insure claimant's full recovery from the consequences of his industrial injury." (App brief at 4). We are uncertain as to whether we have jurisdiction to address claimant's contention, given our decision in Stanley Meyers, 43 Van Natta 2643 (1991). We need not decide that issue, however, because we find that claimant failed to adequately raise this alternative theory of compensability before the Referee. Accordingly, we decline to consider it. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

ORDER

The Referee's order dated December 31, 1991 is affirmed.

September 23, 1992 Cite as 44 Van Natta 1827 (1992)

In the Matter of the Compensation of
DIANA L. BERT, Claimant
WCB Case No. 91-07621
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Charles A. Ringo, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of that portion of Referee Crumme's order that set aside its denial of claimant's claim for a mental disorder as a sequelae of a compensable injury. In her respondent's brief, claimant seeks review of that portion of the order that denied her request for a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee held that claimant's mental disorder was compensable. He based his decision on evidence that the 1986 industrial injury was the major contributing cause of the condition, that the condition, diagnosed as depression, is generally recognized in the medical community, and that the depression arose from factors other than the cessation of employment. On review, the insurer contends that claimant's preexisting personality disorder is the major contributing cause of her depression. Claimant responds that the Referee reached the right result, but argues that he applied the wrong legal standard.

We first address claimant's contention. She argues that the Referee erred in concluding that she was required to prove that her mental disorder is a generally recognized condition which resulted from factors other than the cessation of employment. She contends that those requirements, which are set forth in ORS 656.802(3), do not apply to cases where a mental disorder allegedly arises as a sequelae of a compensable injury. We agree.

Subsequent to the Referee's order, in Boeing Co. v. Viltrakis, 112 Or App 396 (1992), the court held that ORS 656.802 is not applicable when a claimant seeks benefits for a mental disorder that is a consequence of a compensable injury, but does not seek to establish the independent compensability of the disorder. In this case, we conclude that claimant alleges that her depression is compensable as a consequence of the injuries she sustained in her industrial injury. Accordingly, under ORS

656.005(7)(a)(A), claimant is only required to prove the her injury was the major contributing cause of the mental condition. Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

The insurer contends that claimant has failed to carry that burden. It argues that the Referee erred in relying on the opinions of Drs. McMinn and Gibson to find that claimant's compensable injury was the major contributing cause of her mental disorder. It asserts that the Referee should have relied upon the opinions of Drs. Glass and Holland, who opined that claimant's preexisting personality disorder and numerous family problems are the major cause of her depression.

After our review of the record, we agree with the Referee's evaluation of the medical evidence and adopt his conclusions and reasoning. We too are most persuaded by the opinion of Dr. McMinn, the treating psychologist, who explained that, while claimant has a preexisting personality disorder, she had no symptoms of depression prior to the injury and would not be experiencing this significant personality disorder if she had not been injured. Accordingly, we conclude that claimant has established that the 1986 compensable back injury is the major contributing cause of her mental disorder and that the disorder is compensable under ORS 656.005(7)(a)(A).

In an alternative argument, the insurer contends that, even if claimant's depression is compensable, it is responsible only for the treatments provided by Dr. McMinn that were directly related to her injury. It points out that many of Dr. McMinn's session notes refer to claimant's family problems, rather than her health. We are uncertain as to the merits of the insurer's contention, given Dr. McMinn's conclusion that claimant would not have experienced a significant personality disorder had she not been injured. We need not decide the issue, however, because we find that the insurer failed to adequately raise this alternative theory before the Referee. Accordingly, we decline to consider it. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

Penalties

At hearing, claimant argued that the insurer's denial was unreasonable and requested the Referee to impose a penalty pursuant to ORS 656.262(10). The Referee denied claimant's request, finding that the insurer had a legitimate doubt as to its liability. See Brown v. Argonaut Ins. Co., 93 Or App 588 (1988). On review, claimant now contends that she is entitled to a penalty because the denial was unreasonably late. Like the situation above, there is no evidence that claimant raised this alternative theory before the Referee. Accordingly, we decline to consider it on review. Stevenson v. Blue Cross of Oregon, supra.

Attorney Fee on 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 $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 10, 1991 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 insurer.

In the Matter of the Compensation
RAYMOND J. SEEBACH, Claimant
WCB Case No. 91-02703
ORDER ON RECONSIDERATION
Schneider & DeNorch, Claimant Attorneys
Roberts, et al., Defense Attorneys

On August 27, 1992, we withdrew our August 6, 1992 order in which we affirmed those portions of the Referee's order which: (1) directed the insurer to pay temporary disability from August 28, 1990 through September 17, 1990; and (2) assessed a penalty (to be shared equally between claimant and his counsel) based on the aforementioned compensation. We took this action to consider the insurer's contention that a December 1991 Disputed Claim Settlement (DCS) approved by a Referee in another case had effectively mooted our review. In abating our order, we granted claimant an opportunity to respond. In response to our offer, claimant has notified us that he is "not taking a position as to the effect of the DCS." Having received claimant's response, we proceed with our reconsideration.

On July 23, 1991, we acknowledged the insurer's request for Board review of the Referee's July 3, 1991 order. The Referee had held that the insurer was not entitled to stay the payment of claimant's temporary disability for a certain time period. Therefore, the Referee awarded claimant temporary disability for that period, as well as assessed a penalty for unreasonable claim processing.

While our review of that order was pending, the parties entered into a DCS which resolved a subsequent dispute that was pending before the Hearings Division. WCB Case No. 91-12781. That dispute pertained to the insurer's denial of the claim from its inception; i.e., that claimant had not been injured in the course and scope of his employment. Pursuant to the DCS, claimant agreed that the insurer's denial "shall be approved and claimant's Request for Hearing shall be dismissed with prejudice." Claimant also agreed "that he shall receive no more benefits under the Workers' Compensation Act for his claim." On December 20, 1991, the DCS received Referee approval.

On August 6, 1992, we issued our order directing the insurer to pay a portion of the temporary disability granted by the appealed Referee's order. Consistent with our holding, we also adjusted the Referee's penalty assessment.

Unbeknownst to us, the parties had entered into the December 1991 DCS which resolved the dispute regarding the compensability of claimant's injury claim from its inception. Pursuant to that settlement, claimant had agreed that he would receive no further workers' compensation benefits under the claim. The DCS received Referee approval on December 20, 1991. Neither party sought Board review of the DCS within 30 days of its approval. Consequently, the DCS has become final by operation of law. ORS 656.289(3).

Thus, it is the law of this case that claimant's injury claim is not compensable. Moreover, claimant has agreed that he is not entitled to additional benefits in conjunction with this claim. In light of such circumstances, we conclude that claimant relinquished his entitlement to the compensation awarded by the appealed Referee's order prior to the issuance of our August 6, 1992 order. In other words, once the December 1991 DCS became final, our review of this case was effectively moot.

On reconsideration, we hold that the parties' December 1991 DCS has resolved this dispute in lieu of the Referee's July 3, 1991 order. Accordingly, this matter is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM W. SWINT, Claimant
WCB Case No. 91-14261
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Daughtry's order that dismissed claimant's hearing request for lack of jurisdiction. On review, the issue is jurisdiction. We affirm.

FINDINGS OF FACT

Claimant compensably injured his low back in September 1985. Following a period of conservative treatment, his claim was closed by an August 1986 Determination Order with an award of 20 percent unscheduled permanent partial disability.

In April 1990, claimant sought additional treatment for recurring low back pain. The insurer denied payment of the medical services, as well as an aggravation claim. A hearing was convened on December 7, 1990 before Referee Spangler, who found that claimant had sustained a compensable aggravation and that the 1985 injury was the major contributing cause of claimant's need for medical services. We reversed on review, concluding that claimant had experienced a mere "waxing and waning" of symptoms. Accordingly, we reinstated and upheld the insurer's aggravation denial. We did not separately address the medical services claim. Claimant subsequently initiated this proceeding, seeking payment of those medical services and penalties and attorney fees.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that he lacked jurisdiction to consider claimant's request for payment of the medical treatment, because the dispute involved only the reasonableness and necessity of medical services. The Referee relied on our decision in Stanley Meyers, 43 Van Natta 2643 (1991), in which we held that original jurisdiction over such disputes rested with the Director.

On review, claimant argues that Stanley Meyers does not apply, because the issue of compensability of the medical bills was resolved in the prior proceeding. He explains:

> "The propriety of payment of these particular bills has already been litigated. If there was any issue regarding the reasonableness of the medical services, that was an issue which was required to be litigated as part of the denial of these bill in the prior proceeding. * * * The Board should hold that the insurer had to contest the reasonableness of those medical services at the time of litigation of the prior denial." App. brief at 2.

We acknowledge that, in the prior proceeding, we did not disturb Referee Spangler's finding that claimant's compensable injury was the major contributing cause of his need for medical services. However, contrary to claimant's assertion, that proceeding did not determine whether the medical services were reasonable and necessary. Rather, it determined only that the medical services were causally related to the compensable injury. Furthermore, the insurer could not have litigated the reasonableness of those medical services at the prior proceeding, because, just as now, that issue is not a "matter concerning a claim" subject to the initial jurisdiction of the Hearings Division. ORS 656.704(3); Stanley Meyers, supra.

Accordingly, we conclude that we lack jurisdiction to resolve the question of whether claimant's medical services are reasonable and necessary. Therefore, we must dismiss claimant's hearing request.

ORDER

The Referee's order dated January 24, 1992 is affirmed.

In the Matter of the Compensation of
GALDINO VALENCIA, Claimant
WCB Case No. 91-11962
ORDER ON REVIEW
Ginsburg, et al., Claimant Attorneys
Julene Quinn (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of those portions of Referee Podnar's order that: (1) set aside its denial of claimant's injury claim for a lumbar strain/sprain; and (2) set aside its denial of claimant's injury claim for a L5-S1 disc herniation. Claimant cross-requests review of that portion of the Referee's order that: (1) upheld SAIF's denial of claimant's injury claim for degenerative disc disease; and (2) denied claimant's request for attorney fees for an unreasonable denial. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Issue

The initial issue presented is whether the Referee erred in striking a sentence from Exhibit 7F, a report from the Medical Consultants Northwest. The sentence in question noted that claimant was observed walking from the building at a pace faster than that he performed in the examining room. The Referee rejected the sentence on the grounds that it was unclear who had made the observation.

After reviewing that portion of the exhibit, we conclude that it has little probative value and that our decision in this case would not be affected by it. Accordingly, we need not decide whether the sentence was properly excluded and proceed with our de novo review. See Hanna v. SAIF, 65 Or App 649 (1983).

Compensability

The Referee concluded that claimant had failed to establish the compensability of his preexisting degenerative disc disease. The Referee further concluded, however, that claimant had sustained a compensable injury that caused a strain and sprain of his lumbar spine, as well as a herniated disc at L5-S1. After our review of the record, we agree and adopt the Referee's conclusions and reasoning. We add the following supplementation.

On review, SAIF contends that the Referee erred in finding that claimant sustained an "injury." It argues that claimant's testimony at hearing is not reliable and requests that we give more weight to the histories provided in the medical record, which it contends indicate an onset of symptoms without a specific incident.

After our review of the transcript, we find no major discrepancies in claimant's testimony that cast doubt on his reliability. We need not address that issue, however, because we find the histories provided in the medical record are sufficient to establish that claimant sustained an injury in the course of his employment. When claimant first sought treatment from Dr. Gray, he reported that he "was working at the [insured] when he picked up some radio parts, which were not heavy, and turned to sit down and felt a slight twinge of pain in his lower back." (Ex. 2-1). Similarly, he reported to Dr. Colletti that he "turned" at work "and experienced discomfort in the low back." (Ex. 7B.) Thus, contrary to SAIF's assertions, the medical record establishes that claimant sustained an injury while turning at work. SAIF may believe that such an activity is not sufficiently work connected to justify a holding that claimant sustained an injury that arose out of his employment. However, as the court explained in Folkenberg v. SAIF, 69 Or App 159 (1984), "[w]here a specific work activity, whether isolated or repetitive, is part of a claimant's job, the risk of injury from that activity is a risk of that job." Here, there is no dispute that turning to retrieve and deliver electronic parts was a part of claimant's job.

Thus, the risk of injury from that turning was a risk of his job. See also Christine Sutton, 43 Van Natta 2376 (1991).

SAIF also argues that the Referee erred in relying on the opinion of Dr. Gray to find that the injury caused a herniated disc at L5-S1. It contends that Dr. Gray's opinion should be disregarded, because he admitted that he could not state whether the disc herniations preexisted the injury. We recognize that there is an apparent inconsistency, in that, after indicating that the on-the-job injury caused the L5-S1 disc injury, Dr. Gray stated that he did not know whether the disc herniation/protrusion preexisted the injury. (Ex. 11-4). At his deposition, however, Dr. Gray explained that claimant may have had a preexisting disc herniation, but added that, due to the onset of symptoms, that the injury caused some pathological change or some increased herniation or tearing. (Tr. 14-16). Given that explanation, we find Dr. Gray's opinion sufficient to support a finding that the compensable injury was the major contributing cause of claimant's need for treatment and disability related to his herniated L5-S1 disc.

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 issues is $1,187, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's statement of services), the complexity of the issues, and the value of the interests involved.

ORDER

The Referee's order dated January 31, 1992 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of $1,187, to be paid by SAIF.

In the Matter of the Compensation of
GORDON H. VANDERZANDEN, Claimant
WCB Case No. 91-07695
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of those portions of Referee Galton's order that: (1) increased claimant's award of scheduled permanent disability for a right hand injury from 7 percent (10.5 degrees), as awarded by Order on Reconsideration, to 31 percent (46.5 degrees); and (2) directed it to pay claimant's award of scheduled permanent disability at a rate of $305 per degree. In his brief, claimant contends that he is entitled to a greater award of scheduled permanent disability. On review, the issues are extent and rate of scheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant sustained a compensable injury to his right hand on April 21, 1990. His claim was closed by a September 28, 1990 Determination Order that awarded 9 percent scheduled permanent disability for the right hand. Thereafter, claimant requested reconsideration of the Determination Order. On June 11, 1991, an Order on Reconsideration issued which reduced claimant's award to 7 percent scheduled permanent disability. The Order on Reconsideration also ordered that claimant's award of scheduled permanent disability be paid at a rate of $145 per degree.

As a result of the compensable injury, claimant has lost sensation in his right ring finger. Additionally, claimant has lost range of motion in his right middle finger. As a result of the compensable injury, claimant retains 35 degrees of flexion in the distal interphalangeal joint and 80 degrees of flexion in the proximal interphalangeal joint of the right middle finger.

Claimant's compensable injury occurred prior to May 7, 1990.

CONCLUSIONS OF LAW AND OPINION

Extent of Scheduled Permanent Disability

The Referee found that claimant was entitled to increased scheduled permanent disability based on loss of grip strength due to a rotational deformity of the right middle finger. We disagree.

Loss of grip strength is ratable under the standards provided that it is attributable to nerve damage, atrophy, or other anatomical changes due to the compensable condition. Former OAR 436-35-110(3); Martha L. Brunner, 42 Van Natta 2587, 2589 (1990). The measurement of such loss is required to be provided by a physician. Former OAR 436-35-005(1); Robert C. Killion, 42 Van Natta 2109, 2110 (1990).

Here, claimant does have an anatomical change due to the compensable condition. However, there is no medical evidence relating a loss of grip strength to the rotational deformity of the right middle finger. In fact, all Dr. Schludermann indicates with regard to the deformity is that it will be permanent and will not cause much disability. Dr. Schludermann does not relate any loss of grip strength to the deformity. Accordingly, we conclude that claimant has failed to establish that he has a loss of grip strength due to an anatomical change. Therefore, claimant is not entitled to an impairment rating under former OAR 436-35-110(3).

It is undisputed that claimant has a loss of sensation and a loss of range of motion due to the injury. For the loss of sensation in the ring finger, claimant is entitled to a value of 14 percent pursuant to former OAR 436-35-110(1)(a) which equals 1 percent of the hand. Former OAR 436-35-70(7).

Claimant has a 15 degree flexion deformity in the distal interphalangeal joint (DIP) and retains 50 degrees of flexion in his middle finger. Therefore, claimant is entitled to a value of 22.5 percent for retaining 35 degrees of flexion. Former OAR 436-35-60(1). Claimant retains 80 degrees flexion in the proximal interphalangeal joint of his middle finger which entitles him to a value of 12 percent. Former OAR 436-35-060(3). Claimant's value of 22.5 percent is rounded up to 23 percent and combined with the value of 12 percent for a total of 32 percent for loss of range of motion in the middle finger. 32 percent loss of the middle finger equals 6 percent loss of the hand. Former OAR 436-35-070(6).

Claimant's 1 percent value for loss of sensation in the ring finger is added to his 6 percent value of loss of range of motion in the middle finger for a total of 7 percent award of the right hand. Accordingly, the Order on Reconsideration properly calculated claimant's extent of scheduled permanent disability.

Finally, we note that we have previously considered claimant's argument with regard to the validity of the temporary rules and have rejected that argument. See Eileen N. Ferguson, 44 Van Natta 1811 (1992).

Rate of Scheduled Permanent Disability

The Referee concluded that claimant's award of scheduled permanent disability should be paid at the rate of $305 per degree. The Referee relied on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), in which we held that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. Subsequent to the Referee's order, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992).

In this case, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury. ORS 656.202(2); former ORS 656.214(2).

ORDER

The Referee's order dated September 24, 1991 is reversed. The June 11, 1991 Order on Reconsideration is reinstated and affirmed.

September 24, 1992 Cite as 44 Van Natta 1834 (1992)

In the Matter of the Compensation of
DAVID W. MILLER, Claimant
WCB Case No. 91-08318
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Julene Quinn (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Neal's order that affirmed an Order on Reconsideration that increased claimant's unscheduled permanent disability award for his upper back and right shoulder condition from 27 percent (86.4 degrees), as awarded by Determination Order, to 33 percent (105.6 degrees). In his brief, claimant also contends that the "standards" applied by the Referee are not valid. 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

Validity of the "standards"

Claimant first contends that the temporary rules effective 10/1/90 (WCD Admin. Order 6-1988, as amended by WCD Admin. Orders 15-1990 and 20-1990) are invalid and should not have been applied by the Referee. Claimant argues that the rules, or "standards," are invalid because the Administrative Order of Adoption fails to state specific reasons for its findings of prejudice as required by ORS 183.335(5)(a), and because the order of adoption fails to state a legitimate need for any of the temporary rules adopted by that order.

Claimant did not raise a challenge to the validity of the temporary "standards" at hearing. To the contrary, claimant's counsel agreed that the temporary "standards" were the appropriate rules for the Referee to apply. (Tr. 4). Because claimant first raises this issue on review, we decline to address it. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). Moreover, we have recently addressed such a contention in Eileen N. Ferguson, 44 Van Natta 1811 (1992). In Ferguson, we concluded that our express statutory directive is to apply the standards as adopted by the Director. Furthermore, we noted that a direct challenge to the validity of the rules is currently pending in the appellate courts. Ferguson, supra, citing Edmunson v. Dept. of Insurance and Finance (unpublished CA A67544 1-8-92).

In the present case, we apply the rationale provided in Ferguson and we conclude that the Referee correctly applied the temporary rules which were in effect at the time of claimant's claim closure.

Adaptability

Claimant argues that former OAR 436-35-310(3)(b) should not have been used by the Referee in order to determine his adaptability value. Claimant argues that there were no positions available within his capabilities that were offered to him and he was not working at the time of claim closure. Claimant, therefore, contends that his adaptability factor should have been determined pursuant to former OAR 436-35-310(4).

At the outset, we note that claimant's disability, which includes his adaptability value, is determined as of the mailing date of the November 16, 1990 Determination Order. See Vickie M. Libel, 44 Van Natta 413 (1992); Former OAR 436-35-005(8)(now section (12)).

We agree that claimant's adaptability factor falls within former OAR 436-35-310(4). Here, following his surgery, claimant was released for sedentary work and attempted to return to modified work for the employer. Claimant testified that he first attempted to perform work as a trainer, in addition to doing inventory and cleanup work. Claimant also testified that he was unable to perform such work due to pain in his neck and back. Claimant next attempted to work as a spot-welder and when he was unable to do that job, his supervisor told him to go home.

We conclude that the record establishes that claimant left his job because he could not perform the work. Moreover, there is no evidence that the employer subsequently offered available work that claimant could perform. Accordingly, we find that, as of the mailing date of the November 1990 Determination Order, claimant was not working as a result of his compensable back condition. Therefore, claimant is entitled to an adaptability factor of 8, as Dr. Brett has found claimant capable of sedentary work. Former OAR 436-35-310(4); George A. Ferguson, 44 Van Natta 11 (1992). (We note that a value of 10 may be awarded where claimant is unable to perform the full range of sedentary activities because of restricted abilities to sit, stand, walk, etc. However, after reviewing Dr. Brett's reports, we do not find the additional restrictions severe enough to warrant a value of 10.)

Impairment

We adopt the Referee's "Opinion" on the issue of impairment.

Having determined each value necessary to compute claimant's permanent disability, we proceed to that calculation. When claimant's age value, 0, is added to his education value, 3, the sum is 3. When that value is multiplied by claimant's adaptability value, 8, the product is 24. When that value is added to claimant's impairment value, 22, the result is 46 percent unscheduled permanent disability. Claimant's permanent disability under the standards is, therefore, 46 percent.

ORDER

The Referee's order dated September 27, 1991 is modified. In addition to prior Determination and Reconsideration Order awards, claimant is awarded 13 percent (41.6 degrees) unscheduled permanent disability for his upper back and right shoulder condition, giving him a total award to date of 46 percent (147.2 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the increased compensation created by this order. However, the total attorney fee awarded by the Referee and our order shall not exceed $3,800.

In the Matter of the Compensation of
ROBERT B. MILLS, Claimant
WCB Case No. 91-11767
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys
David L. Jorling, Defense Attorney

Reviewed by Board Members Gunn and Brazeau.

The self-insured employer requests review of those portions of Referee Galton's order that: (1) affirmed an Order on Reconsideration that found claimant to be medically stationary on January 18, 1991; and (2) decreased the employer's offset of unscheduled permanent disability from 30 percent, as allowed by Order on Reconsideration, to 22 percent. On review, the issues are medically stationary date and extent of unscheduled permanent disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Medically stationary date

We adopt the Referee's conclusions and reasoning concerning the medically stationary date.

Extent of unscheduled permanent disability

In his Corrected Opinion and Order, the Referee modified the Order on Reconsideration and decreased, by 8 percent unscheduled permanent disability, the amount of offset allowed by the Reconsideration Order. We disagree.

On review, the employer contends that claimant has been doubly compensated for his low back condition. The employer argues that ORS 656.222 provides that claimant's current award should be reduced by the amount of loss of earning capacity that was previously provided for in the February 1988 Determination Order.

We conclude that the Order on Reconsideration correctly allowed an offset of 30 percent. Although the court held that ORS 656.222 is limited to subsequent awards of scheduled permanent disability, see City of Portland v. Duckett, 104 Or App 318 (1990), we have held that ORS 656.214(5) requires that unscheduled permanent disability due to a compensable injury be determined by comparing the worker before such injury and without such disability. See Mary A. Vogelaar, 42 Van Natta 2846 (1990). Thus, once a figure for claimant's unscheduled permanent disability has been calculated, it must next be determined to what extent such disability figure includes unscheduled permanent disability already in existence.

In the present case, a February 16, 1988 Determination Order had previously awarded claimant 30 percent unscheduled permanent disability under the "standards" for his compensable low back condition. Following the 1988 Determination Order, claimant underwent a laminectomy that was related to his compensable low back condition. The subsequent Determination Order, which issued in April 17, 1991, provided that claimant's total award had been increased by 2 percent unscheduled permanent disability. Accordingly, claimant had been awarded a total of 32 percent unscheduled permanent disability, 30 percent of which had previously been compensated by the 1988 Determination Order award. The Order on Reconsideration affirmed the April 17, 1991 Determination Order.

Under the circumstances, we find that the Order on Reconsideration correctly reduced the total 32 percent award by the previously awarded 30 percent unscheduled permanent disability, to the extent that the subsequent award compensated claimant for permanent disability that was previously present. Therefore, that portion of the Order on Reconsideration is affirmed.

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 medically stationary date issue is $500, 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 December 26, 1991, as corrected by the January 17, 1992 order, is reversed in part and affirmed in part. That portion which decreased the employer's offset of permanent disability by 8 percent is reversed. That portion of the Order on Reconsideration that permitted a reduction of 30 percent unscheduled permanent disability, is reinstated and affirmed. The remainder of the Referee's order is affirmed. For services on review concerning the medically stationary date issue, claimant's counsel is awarded an assessed attorney fee of $500, payable by the self-insured employer.

In the Matter of the Compensation of
JOHN L. VALUM, Claimant
WCB Case No. 91-18098
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Black's order that declined to award a carrier-paid attorney fee under ORS 656.386(1) when claimant successfully requested a hearing contesting the insurer's termination of temporary disability. On review, the issue is attorney fees.

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

Claimant contends that he is entitled to a carrier-paid attorney fee under ORS 656.386(1) because his attorney was instrumental in obtaining compensation. We agree that claimant's counsel was instrumental in obtaining compensation for claimant. Nevertheless, to receive a carrier-paid fee under ORS 656.386(1), claimant must prevail against a denial of compensability. See Short v. SAIF, 305 Or 541, 545 (1988); Euzella Smith, 44 Van Natta 778 (1992). Furthermore, the provision of the statute that claimant relies on requires that no hearing be held. See Multnomah County School District v. Tigner, 113 Or App 405 (1992).

Here, a hearing was held concerning claimant's request for the resumption of his temporary disability. He was successful in that effort. However, for the reasons detailed above, ORS 656.386(1) is not applicable. Rather, we agree with the Referee that claimant's attorney is entitled to a fee payable from claimant's increased compensation. ORS 656.386(2); OAR 438-15-045.

ORDER

The Referee's order dated February 14, 1992 is affirmed.

In the Matter of the Compensation of
JEANNIE L. SHELTON, Claimant
And, In the Matter of the Complying Status of
JOHN T. and FAY E. JENSEN, Employers
WCB Case Nos. 91-00894 & 90-21423
SECOND ORDER ON RECONSIDERATION
Karen M. Werner, Claimant Attorney
David Ray Fowler (Saif), Defense Attorney
O'Neill, et al., Attorneys

The noncomplying employer requests reconsideration of our July 31, 1992 Order on Review, as reconsidered August 27, 1992, which found that claimant's injury claim was compensable. Specifically, the employer, apparently through substitute counsel, contends that neither the Referee nor the Board considered its argument that claimant was not a subject worker and it was not a subject employer because the two parties had entered into a joint venture.

We disagree with the employer's assertion that the issue of the parties' status as a partnership or joint venture was "argued throughout" these proceedings. In opening remarks at hearing, the issues were framed as compensability and whether the employer was noncomplying and a subject employer at the time of claimant's injury. The employers' former counsel contended that the employers' position was that "they are not employers because (claimant) was an independent contractor and, therefore, they're not noncomplying employers." (Tr. 5). Further, in written argument to the Referee, the employer's counsel again asserted that claimant was an independent contractor.

Finally, the issue of a partnership or joint venture between claimant and the employers was not litigated on Board review. In this regard, the employer did not submit a brief on Board review.

Under the circumstances, we conclude that the issue of the parties' status as a partnership or joint venture was neither raised at hearing, nor initially on Board review. Accordingly, we decline to address it for the first time on reconsideration. See Mavis v. SAIF, 45 Or App 1059 (1980).

On reconsideration, as modified herein, we adhere to and republish our July 31, 1992 order, as modified by the August 27, 1992 order on reconsideration. 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
ELIZABETH A. RICE, Claimant
WCB Case No. 91-09539
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Kinsley and Brazeau. [1]

The insurer requests review of those portions of Referee Galton's order that: (1) awarded claimant 14 percent (21 degrees) scheduled permanent disability benefits for the loss of use or function of the left hand; and (2) directed it to pay the scheduled permanent disability award at the rate of $305 per degree. Claimant cross-requests review by raising the following issues in her brief: (1) a penalty should be assessed for the insurer's allegedly frivolous appeal; and (2) the insurer should be ordered to pay interest on compensation stayed pending the insurer's appeal. On review, the issues are extent and rate of scheduled permanent disability, penalties, and interest. We vacate.

FINDINGS OF FACT

Claimant filed a claim for a work injury occurring on August 15, 1989. The claim was accepted and closed by Determination Order on December 18, 1990.

Claimant requested reconsideration by the Workers' Compensation Division's Appellate Review Unit. She made her request on a form provided by the Division. On the form she checked the box indicating that she objected to the impairment findings by her attending physician. Drs. McKillop, Logan and Rich of the Orthopaedic Consultants were subsequently appointed medical arbiters. They performed their examination on November 11, 1991, and issued their report that same day.

Meanwhile, on August 30, 1991, the Appellate Review Unit issued its Order on Reconsideration which affirmed the Determination Order. 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."

CONCLUSIONS OF LAW AND OPINION

Claimant became medically stationary after July 1, 1990. Therefore, the 1990 amendments to the Workers' Compensation Law apply to this case. See Oregon Laws 1990 (Special Session), ch 2, § 54(3).

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).

Subsequent to the Referee's order, we have 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, 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, recon den 44 Van Natta 1609 (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.

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[1] Board Member Hooton has previously represented one of the parties to this proceeding. Consequently, he has not participated in this review. OAR 438-11-023.

The Order on Reconsideration was issued before the medical arbiters had examined claimant and reported their findings. Thus, the medical arbiters' findings were not considered before issuance of the Order on Reconsideration, as required by ORS 656.268(7).

Where the Director does not comply with the mandatory procedure set forth in ORS 656.268(7), 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 arbiters' findings. Under such circumstances, the Order on Reconsideration is invalid. Accordingly, the Referee lacked jurisdiction to consider the Order on Reconsideration.

ORDER

The Referee's order dated December 10, 1991 is vacated. Claimant's hearing request is dismissed for lack of jurisdiction.

In the Matter of the Compensation of
GONZALO M. CERVANTES, Claimant
WCB Case No. 90-18249
SALVADOR C. CERVANTES, Claimant
WCB Case No. 90-17947
ISAAC Z. OCHOA, Claimant
WCB Case No. 90-17949
JOSE I. JIMENEZ, Claimant
WCB Case No. 90-17948
ORDER ON REVIEW
Sellers & Jacobs, Claimant Attorneys
Max Rae, Claimant Attorney
Steven Cotton (Saif), Defense Attorney
Garrett, et al., Defense Attorneys
Norman Kelley, Assistant Attorney General

Reviewed by Board en banc.

Claimants request review of Referee Quillinan's order that determined that the SAIF Corporation, as the processing agent for the noncomplying employer, was entitled to offset temporary disability benefits paid by the Washington Industrial Insurance Fund against temporary disability benefits due to be paid on their respective Oregon claims. On review, the issue is offset. We reverse.

FINDINGS OF FACT

The substantive facts underlying these four consolidated cases are identical. Claimants were employed as seasonal workers for Northwest Greentree, an Oregon corporation that does reforestation work in Oregon and Washington. Each claimant suffered a work-related injury and filed claims for benefits first in Washington and then in Oregon. The Washington Industrial Insurance Fund accepted the Washington claims and paid benefits. In response to the Oregon claims, the Compliance Section of the Workers' Compensation Division issued a proposed order declaring the employer to be a noncomplying employer and referred the claims to SAIF for processing. SAIF ultimately accepted all four claims and also paid benefits.

On July 12, 1990, the employer requested the Director of the Department of Insurance and Finance to authorize an offset of temporary disability benefits paid to claimant Salvador Cervantes-Ochoa on his Washington claim against temporary disability benefits due to be paid him by SAIF on his Oregon claim. On July 19, 1990, SAIF made a similar request with regards to claimant Isaac Z. Ochoa. By letter dated July 20, 1990, the Administrator of the Workers' Compensation Division, on behalf of the

Director, authorized the request with regards to Salvador Cervantes-Ochoa. His letter provides, in pertinent part:

> "While neither ORS Chapter 656 nor the administrative rules address this situation, our courts have determined a worker is not entitled to recover double compensation when there is uncertainty as to who is responsible for the claim. This case differs only in that the uncertainty stems from whether Mr. Cervantes-Ochoa was a Washington worker or an Oregon worker.
>
> "In the absence of specific statutory language, I must look to the spirit and intent of the law and the related court decisions. In that context, I do not find any basis for permitting a worker to be doubly compensated. The notion of double compensation is contrary to the central intent to protect both workers and employers. The question whether the employer was noncomplying in Oregon is a moot issue to this matter.
>
> "Therefore, I will authorize the requested offset of compensation paid on the Washington claim against compensation due under the Oregon claim under ORS 656.210." (Ex. 4).

The Director reconsidered the decision by letter dated August 24, 1990, and found it appropriate under the circumstances and extended its application to the claims of the other three claimants. At the time the Director's decision, only two of the four Oregon claims had been closed. A Notice of Closure later closed Salvador Cervantes-Ochoa's claim on October 18, 1990. There is no evidence in the record that Jose I. Jimenez's claim has been processed to closure.

On September 10, 1990, claimants requested hearings to challenge the Director's decision. The requests were consolidated, and a hearing was convened on March 25, 1991.

CONCLUSIONS OF LAW AND OPINION

Preliminary Issues

Before we reach the central issue presented in this case, i.e., whether the Director had the authority to order an offset of extraterritorial benefits, we must address two preliminary issues. First, claimant Jose J. Jimenez has requested remand for consideration of a June 19, 1991 Notice of Decision, in which the Washington Department of Labor and Industries has ordered him to repay $3,577.38 as overpayment in time loss compensation. His attorney asks that further evidence be taken on the ultimate resolution of this matter to prevent claimant from going uncompensated.

We may remand to the Referee for the taking of additional evidence if we find that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Evidence of Washington's decision to recover benefits may be relevant to the calculation of benefits owed claimant under Oregon law, provided that SAIF is allowed to offset the out-of-state benefits. However, we do not find the decision relevant to the issue of whether the Director had the authority to allow such an offset. Accordingly, we do not find the record to be incompletely developed. The request for remand is denied.

The second preliminary issue is one of jurisdiction. The Director contends that the Hearings Division lacks jurisdiction to review its decision authorizing the offset. We disagree. The offset decision directly involves claimants' "right to receive compensation, or the amount thereof," and it is therefore a "matter concerning a claim," subject to the jurisdiction of the Hearings Division. ORS 656.704(3).

Offset

The Referee determined that the Director had acted without authority in allowing SAIF to offset benefits previously paid in Washington pursuant to claims arising from the same injuries. On her own motion, however, the Referee concluded that the decision was necessary to prevent double recovery of benefits and authorized the offset herself.

After our review, we agree with the Referee's initial determination. The scope of a regulatory or

administrative agency's authority cannot exceed that which is specifically delegated by the legislature. 1000 Friends of Oregon v. LCDC, 301 Or 622 (1986). In this regard, the Director acknowledges that, at the time of his decision, there was no statutory or administrative rule authorizing his determination.[1] Nonetheless, it cites Jackson v. SAIF, 7 Or App 109 (1971), and argues that an offset of extraterritorial benefits was mandated by its statutory duties to regulate and administer the Oregon workers' compensation system.

Jackson involved a claimant who had sustained two separate Oregon injuries, each of which resulted in temporary total disability. Because the evidence showed that each injury was in itself sufficient to cause total disability, the Board, which then also acted as a regulatory body, ordered a pro-rate between insurance carriers. The court affirmed the Board's determination. Finding that ORS 656.210 limited the amount of temporary disability compensation an injured worker could receive, the court concluded that, in order to comply with that limitation, the Board properly reduced the amount owed by each insurer to 50 percent of the statutorily allowable total.

Although claimants here are similarly entitled to benefits from two sources, we do not find the limiting analysis of Jackson transferable to the concurrent payment of benefits from out-of-state sources. For purposes of the Workers' Compensation Law, "compensation" is defined as "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 this chapter." ORS 656.005(8). (Emphasis supplied.) Because Washington benefits are not paid pursuant to ORS Chapter 656, claimants' prior receipt of such benefits could not result in payment of compensation greater than that allowed by ORS 656.210.

Finding no other source of authority, we agree with the Referee that the Director was without authority to allow SAIF to offset benefits previously paid by the Washington Industrial Insurance Fund. We do not agree, however, with the Referee's own authorization of such an offset. The record reveals that no party asked the Referee to determine whether an offset of extraterritorial benefits was proper under the law in the event she decided that the Director acted without authority. Rather, she was asked only to decide the issue of the Director's authority. Inasmuch as the issue was not raised, we conclude that it was improper for the Referee to decide it sua sponte. As we explained in Michael R. Petrovich, 34 Van Natta 98 (1982):

> "Referees (and this Board too) should concentrate on making the best possible decisions on the issues raised by the parties without distraction of volunteering decisions on issues not raised."

Accordingly, we vacate that portion of the Referee's order. See also Theodore W. Lincicum, 40 Van Natta 1760 (1988).

ORDER

The Referee's order dated May 28, 1991 is affirmed in part and vacated in part. That portion of the Referee's order that determined that the SAIF Corporation, as the processing agent for the noncomplying employer, was entitled to offset temporary disability benefits paid by the Washington Industrial Insurance Fund against temporary disability benefits due to be paid on their respective Oregon claims is vacated. The remainder of the order is affirmed. Claimants' attorneys are awarded 25 percent of the increased compensation created by this order, payable directly to claimants' attorneys.

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[1] The Director has since promulgated OAR 436-60-020(9), effective December 1990, which allows offset of extraterritorial benefits with the Director's approval.

In the Matter of the Compensation of
MARTHA E. PARDUE, Claimant
WCB Case No. 91-10278
ORDER ON REVIEW
Empey & Dartt, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Bethlahmy's order that increased claimant's unscheduled permanent disability award for a low back injury from 2 percent (6.4 degrees), as awarded by an Order on Reconsideration, to 7 percent (22.4 degrees). In its brief, the self-insured employer argues that the Referee's award should be reduced. 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 Referee applied the standards in effect at the date of claim closure. We agree. The rules in effect on the date of the Notice of Closure or Determination Order control. OAR 438-10-010(2); OAR 436-35-003(1); former OAR 436-35-003 & former OAR 436-35-003. In this case, the applicable rules are those in effect on February 6, 1991, the date the Determination Order issued. WCD Admin. Order 6-1988 as amended by temporary rules adopted effective October 1, 1990 and November 20, 1990 (WCD Admin. Orders 15-1990 & 20-1990) are the rules which apply to the present case.

Both at hearing and on review, claimant argues that the temporary rules adopted by WCD Admin. Orders 15-1990 & 20-1990 are invalid. Therefore, claimant argues, only the rules adopted by WCD Admin. Order 6-1988 apply to her case. We recently rejected that argument in Eileen N. Ferguson, 44 Van Natta 1811 (1992). Thus, we find that the temporary rules noted above apply to this case.

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.

Claimant was working at her regular work at the time of the Determination Order. Relying on former OAR 436-35-310(2)(a), the Referee found that claimant's adaptability value is 0. The parties do not dispute this value. Because the adaptability value is used as a multiplier in calculating claimant's disability, and the adaptability value here is 0, only the impairment value is at issue.

The Referee found claimant entitled to 2 percent impairment for lost range of motion in the lumbar spine and 5 percent impairment for a chronic condition limiting repetitive use of the lumbar spine, for a total of 7 percent (22.4 degrees) unscheduled permanent disability.

Regarding the impairment to claimant's lumbar spine, claimant argues that she is also entitled a 4 percent value for the broad annular bulging at L4-5. (Ex. 24). However, we agree with the Referee that claimant has not proved that this annular bulge is related to her compensable lumbar strain.

In his December 27, 1990 closing examination, Dr. Wong, attending physician, explained the results of an MRI by stating that "there is decreased signal at the L4-5 interspace level consistent with

degenerative disc disease. There is annular bulging at L4-5, symmetrical, without herniation." (Ex. 31-1). This interpretation matches that of the doctor who performed the MRI. (Ex. 24). On March 12, 1991, in response to a letter from claimant's attorney, Dr. Wong stated that the "industrial injury[,] in my opinion[,] of 3/13/90 is the major contributing cause of her condition." (Ex. 34-2). However, this conclusory opinion does not explain the relationship of the annular bulge to the work injury. Also, it does not explain Dr. Wong's apparent change of opinion with his earlier statement where he attributed the MRI findings to degenerative disc disease. See Moe v. Ceiling Systems, 44 Or App 429 (1980) (an unexplained change of opinion is given little probative weight). Thus, we find that claimant has not established that the annular bulge is causally related to her compensable lumbar strain. In addition, we note that, even if the record had established causation, the applicable standards no longer provide an impairment value for this condition. OAR 436-35-350(2); WCD Admin. Order 15-1990

Claimant is entitled to a 2 percent value for loss of range of motion in her lumbar spine. Former OAR 436-35-360(6) and (7); Ex. 31-2. Claimant also has a chronic condition that limits repetitive use of her lumbar spine. (Ex. 34-10). On review, the employer argues that claimant is entitled to a total lumbar impairment value of 5 percent. We agree. The applicable standards provide that, where the impairment in the body area totals less than 5 percent, the worker is entitled to 5 percent "unscheduled chronic condition impairment in lieu of all other unscheduled impairment in that body area." Former OAR 436-35-320(5)(b). Thus, because claimant's total lumbar impairment is 2 percent, she is entitled to a 5 percent value for her chronic condition impairment in lieu of all other unscheduled lumbar impairment.

Claimant also argues that she is entitled to an impairment value for loss of range of motion in her hips. In support of this argument, claimant relies on Dr. Wong's March 12, 1991 statement as quoted above. (Ex. 34-2). However, we do not find this conclusory statement persuasive. Claimant had no complaints or treatment regarding her hips following the work injury. Also, Dr. Wong does not explain how the compensable lumbar injury caused the bilateral loss of range of motion in claimant's hips.

Therefore, we find that claimant's permanent disability under the standards is 5 percent.

ORDER

The Referee's order dated December 9, 1991 is modified. In lieu of the Referee's award and in addition to the 2 percent (6.4 degrees) unscheduled permanent disability awarded by an Order on Reconsideration, claimant is awarded 3 percent (9.6 degrees), giving her a total award to date of 5 percent (16 degrees) unscheduled permanent disability for a low back injury. Claimant's attorney fee shall be adjusted accordingly.

In the Matter of the Compensation of
ELIZABETH A. RICE, Claimant
WCB Case No. 91-09539
ORDER OF ABATEMENT
Peter O. Hansen, Claimant Attorney
Charles Lundeen, Defense Attorney

An Order on Review issued in this matter on September 17, 1992. In that order, we vacated the Referee's order and dismissed claimant's hearing request for lack of jurisdiction, finding that the Director's Order on Reconsideration was invalid because it was issued prior to the Director's consideration of the medical arbiters' report. See Olga I. Soto, 44 Van Natta 697, recon den 44 Van Natta 1609 (1992).

Subsequent to the issuance of our order, we have determined that further consideration should be given to our decision. Specifically, we wish to consider the effect, if any, of the parties' purported waiver of procedural irregularities regarding a medical arbiter.

In order to allow time for further consideration, we hereby abate our September 17, 1992 order. To assist us in our deliberation, we ask that the parties submit their respective positions concerning the effect, if any, of Anaconda v. Dept. of Rev., 278 Or 723 (1977). The parties are requested to file their submissions within 14 days from the date of this order. Thereafter, we shall proceed with further consideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL W. KING, Claimant
WCB Case No. 90-08311
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Susan D. Ebner (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of that portion of Referee Hoguet's order that directed it to pay claimant's scheduled permanent disability award at the rate of $305 per degree. Claimant cross-requests review of that portion of the order that increased claimant's unscheduled permanent partial disability award from 19 percent (60.8 degrees), as awarded by an April 12, 1990 Determination Order, to 23 percent (73.6 degrees). On review, the issues are the rate of scheduled permanent disability and extent of unscheduled permanent disability. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Rate of Scheduled Permanent Disability

The Referee concluded that claimant's award of scheduled permanent disability should be paid at the rate of $305 per degree. The Referee relied on Alan G. Herron, 43 Van Natta 267, on recon 43 Van Natta 1097 (1991), in which we held that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to $305 per degree, applied to awards made on or after May 7, 1990, regardless of the date of injury. Subsequent to the Referee's order, the Court of Appeals reversed our decision in Herron, concluding that the legislature intended the increased rate of compensation to apply only to injuries that occurred on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992).

In this case, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. SAIF v. Herron, supra. Rather, claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury. ORS 656.202(2); former ORS 656.214(2).

Extent of Unscheduled Permanent Disability

For purposes of determining injury related permanent partial disability, ORS 656.283(7) and 656.295(5) require application of the standards for the evaluation of disabilities adopted by the Director pursuant to ORS 656.726(3)(f)(A). Because claimant became medically stationary on February 26, 1990, we apply the standards effective at that time in rating claimant's permanent disability. (WCD Admin Order 6-1988.) OAR 436-35-003(1).

The determination of unscheduled permanent partial disability is made by determining the appropriate values assigned by the standards to a claimant's age, education, adaptability and impairment. In this case, the Referee concluded that claimant was entitled to no value for his age, a

value of 1 for education, and a value of 2.5 for adaptability. The Referee also determined that claimant was entitled to awards of 4 percent impairment for each disc bulge and surgery and 9 percent impairment for lost range of motion, for a total impairment value of 20 percent.

On review, claimant challenges only the Referee's denial of his request for an additional 5 percent impairment for loss of forward flexion. Claimant acknowledges that the most recent range of motion findings--those contained in an April 1991 chart note--did not conform to those found in the standards. He argues, however, that the Referee erred in failing to consider those range of motion findings given by Dr. Markham in September 1990. We agree.

Where the treating physician's range of motions findings do not conform to those found in the standards, we do not find those findings persuasive in rating the extent of a claimant's permanent impairment. Lawrence E. Wilson, 43 Van Natta 1131 (1991). In such situations, however, other range of motion findings, if they exist, should be used in determining impairment. Id. Here, Dr. Markham reported in September 1990 that claimant had retained only 40 degrees of active range of motion of forward flexion. While that finding was made some 15 months prior to hearing, it was made after claimant was declared medically stationary and it is not otherwise disputed by SAIF. For those reasons, we find it sufficient medical evidence to support an additional award of 5 percent unscheduled permanent partial disability under the standards for loss of motion. See OAR 436-35-360(6). Adding that value to claimant's other 9 percent award for loss of range of motion, and then combining that sum of 12 with claimant's 12 percent award for surgery and disc bulges, we find that claimant is entitled to a total impairment value of 23 percent. Former OAR 436-35-360(10) and (11).

Accordingly, utilizing the other uncontested values under the standards, we rate claimant's disability as follows. When claimant's age value 0 is added to his education value 1, the sum is 1. When that value is multiplied by claimant's adaptability value 2.5, the product is 2.5. When that value is added to claimant's impairment value 23, the result is 25.5 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage, for a total disability award of 26 percent.

ORDER

The Referee's order dated February 18, 1992 is reversed in part and modified in part. That portion of the Referee's order that directed the SAIF Corporation to pay claimant's scheduled disability award at the rate of $305 per degree is reversed. In addition to the Determination order the Referee's award of 23 percent (73.6 degrees) unscheduled permanent disability, claimant is awarded 3 percent (9.6 degrees) for a total of 26 percent (83 degrees) unscheduled permanent partial disability. Claimant attorney is entitled to an attorney fee equal to 25 percent of the increased compensation made payable by this order, but the total attorney fee awarded by the Referee's order and this order shall not exceed $3,800.

In the Matter of the Compensation of
CHERYL J. LEWIS, Claimant
WCB Case No. 91-10026
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Michael O. Whitty (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Spangler's order that upheld the SAIF Corporation's denial of claimant's back injury claim. On review, the issue is subjectivity. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee, relying on Kerns v. Guido-Lee, 107 Or App 721 (1991), found that claimant was a "domestic servant" under former ORS 656.027(1) and, therefore, was not a subject worker. Claimant first objects to the Referee's application of Kerns, asserting that it is factually distinguishable. Claimant also contends that, even if Kerns is applicable, the legislature intended that the statute be construed as applying only to those persons working under a private employment contract.

Former ORS 656.027(1) provided that a "nonsubject worker" includes a "worker employed as a domestic servant in or about a private home. For the purposes of this subsection 'domestic servant' means any worker engaged in household domestic service."

In Kerns v. Guido-Lee, supra, the Court of Appeals considered whether the applicability of former ORS 656.027(1) depended on the injured worker's relationship with the employer or whether it should turn on the nature of the work performed. The court found that "[w]hat is relevant is the nature of the work performed and its relation to the home, not the identity of the persons arranging for, supervising, controlling or benefitting from the service." 107 Or App at 724.

Furthermore, the court declined to construe the statute to exempt only those workers who contract with a private homeowner to provide direct, personal domestic service. The claimant urged such a construction based on her stated contention that the purpose of the statutory exception was to relieve only nonbusiness householders from the burden of providing workers' compensation benefits. The court rejected the claimant's suggestion, stating that "[u]nder the plain language of the statute, claimant is a domestic servant and is, therefore, not entitled to compensation." Id. at 725.

Claimant asserts that Kerns is distinguishable because, unlike in the present case, the claimant in Kerns was paid directly by homeowners and the employer was a referral service. As stated by the Kerns court, the applicability of former ORS 656.027(1) depends on the nature of the work performed rather than the employment relationship. Here, there is no argument that claimant did not perform the work of a domestic servant. Therefore, whatever her relationship with the employer, the statute's "domestic servant" exception applied to claimant. Consequently, we find that the difference between claimant's employment relationship and the employment relationship of the claimant in Kerns is of no legal significance to the question of statutory interpretation presented. Accordingly, we conclude that claimant was a "non-subject worker."[1]

ORDER

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

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[1] Although a signatory to this order, Board Member Gunn submits that the Board's decision in Kerns v. Guido-Lee, supra, and the court's affirmance of that decision were contrary to legislative intent and purpose, and were erroneous. In the opinion of Member Gunn, the legislature did not intend to apply the "domestic servant" exception to an injured worker like the claimant who works for an employer engaged for profit in the business of housekeeping. In Member Gunn's view, the obvious and limited purpose of the exception was to enable private citizens not engaged in the housekeeping business for profit to hire an individual to clean their homes without having to carry workers' compensation insurance coverage. By focusing on the type of work performed without considering the nature of the employment relationship, the Kerns holding is analytically flawed and anomalous in its result. Recognizing that the Kerns holding controls the outcome of the present case, Member Gunn urges the Court of Appeals to reexamine and reject the Kerns analysis in its review of the present case.

In the Matter of the Compensation of
JOEL O. SANDOVAL, Claimant
WCB Case No. 91-08365
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Michael V. Johnson's order which declined to direct the insurer to pay claimant temporary total disability benefits awarded by an earlier Referee's order, on the ground that payment of the benefits was stayed pending review by the Board. On review, the issue is stay of compensation pending Board review.

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

Claimant argues that the insurer was obligated to pay temporary total disability pursuant to ORS 656.262(4) because it it did not request Board review within 14 days of the prior referee's order. The insurer contends that ORS 656.313(1) allows it to stay payment of temporary total disability so long as it appeals a referee's order within 30 days. We agree.

We have previously addressed this issue in Walden J. Beebe, 43 Van Natta 2430 (1991). In Beebe, we held that the filing of a request for review of a Referee's order by a carrier within 30 days stays the payment of the compensation appealed without any limitation or exception as to when, within the 30 day period, the carrier's appeal is filed. We further held that ORS 656.262(4) establishes the timeliness of the payment of compensation that is due. Compensation stayed pending Board review is not due for the purpose of ORS 656.262(4). ORS 656.262(4) does not apply when the compensation appealed has been stayed pursuant to ORS 656.313(1). Id.

Here, the insurer requested Board review of the prior Referee's order within 30 days. Thus, there was no compensation due and the insurer was not required to pay the compensation at issue within 14 days.

ORDER

The Referee's order dated December 11, 1991 is affirmed.

In the Matter of the Compensation of
GARY WHISENANT, Claimant
WCB Case No. 91-13162
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Roberts et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee Brown's order that set aside its denial of claimant's claim for a low back injury. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the August 12, 1991 incident at the employer constituted a new injury. We disagree.

Claimant sustained a low back injury at SAIF's insured in November 1989. The claim was closed in April 1991 with a 25 percent permanent partial disability award. The claim was reopened for vocational training in July 1991. Claimant participated in an authorized training program as a truck dispatcher. He was terminated from that program on July 30. On his own, claimant found a job driving a front-end loader for the employer. Claimant's physician conditionally released him to try the front-end loader job, but anticipated further problems with claimant's low back. This job began on August 8, 1991. On August 12, 1991, claimant was driving the front-end loader looking over his left shoulder in a twisted position when the left wheel of the vehicle went into a hole. Claimant felt a pop and had onset of pain in the left side of his low back. Claimant filed a claim with the employer. The employer denied responsibility only on September 9, 1991. SAIF continued to process claimant's 1989 claim, did not deny responsibility for claimant's current low back condition, and was not a party to this proceeding.

On review, the employer contends that its denial was sufficient to raise the issue of its continuing liability under ORS 656.005(7)(a)(B) and asserts that the Referee should have ruled on this issue. However, regardless of whether or not the issue was raised, the "preexisting condition" to which the parties appear to refer is the prior compensable injury with SAIF. We have rejected the argument that a prior compensable injury constitutes a preexisting condition under ORS 656.005(7)(a)(B). Rosalie S. Drews, 44 Van Natta 36 (1992); John L. Law, 44 Van Natta 1091 on recon 44 Van Natta 1619 (1992).

Next, the employer argues that, assuming that the applicable standard here is a material contributing cause standard, that standard was not met and claimant did not sustain a new injury. We agree.

In order to prove a new compensable injury, it must be established that the August 1991 incident was a material contributing cause of claimant's disability or need for treatment. ORS 656.005(7)(a); Mark N. Weidle, 43 Van Natta 855 (1991). The injury must be established by medical evidence supported by objective findings. See ORS 656.005(7)(a); ORS 656.005(19); Suzanne Robertson, 43 Van Natta 1505 (1991).

Whether or not claimant sustained a new compensable injury in August 1991 or merely experienced a continuation of the 1989 injury is a complex medical question; expert evidence is required to resolve it. Uris v. Compensation Department, 247 Or 420 (1967). Here, Dr. Henderson, claimant's attending physician, has stated: "I do not feel that the injury while working at [the employer] significantly changed the overall picture. I think that all of his problems are still related to his original injury." (Emphasis added). Claimant was not present at hearing and did not testify; however, the record indicates that he reported that he left the authorized training program in July 1991 because his pain symptoms due to the 1989 injury had increased to the point that he could no longer tolerate the position. Furthermore, the SAIF claim stemming from the 1989 injury was still in open status when the August 1991 incident occurred. SAIF did not attempt to disclaim responsibility for claimant's August 1991 disability. Finally, Dr. Henderson only conditionally released claimant to do the front end loader job and anticipated further problems with claimant's back. He stated:

> "This job puts a high amount of twisting movements on the spine. Shock absorption is minimal and stresses are transmitted to the spine. Weights are significantly higher than he demonstrated during work evaluation. My concern is that the patient will eventually run into problems at this level of work."

Based on Dr. Henderson's undisputed opinion regarding the causation of claimant's 1991 disability and need for treatment, we are not persuaded that the August 1991 incident was a material contributing cause of that disability and treatment. Therefore, we find that claimant did not sustain a new compensable injury in August 1991. We find, rather, that as anticipated by Dr. Henderson, claimant experienced increased symptoms from his 1989 compensable injury while performing duties that were beyond his physical capacity. See Taylor v. Multnomah County School Dist. No. 1, 109 Or App 499 (1991). On this basis, we conclude that the employer's denial should be upheld.

ORDER

The Referee's order dated January 16, 1992 is reversed. The employer's denial of claimant's low back condition is reinstated and upheld. The Referee's attorney award is reversed.

In the Matter of the Compensation of
BETTY J. FULMORE, Claimant
WCB Case No. TP-92007
THIRD PARTY DISTRIBUTION ORDER
Hollander & Lebenbaum, Claimant Attorneys
Tooze, et al., Defense Attorneys

Claimant has petitioned the Board to resolve a dispute concerning a "just and proper" distribution of proceeds from a third party settlement. ORS 656.593(3). Specifically, the dispute pertains to whether Hartford Insurance, as a paying agency, is entitled to a share of the $30,000 settlement proceeds stemming from a motor vehicle accident which occurred before claimant's condition resulting from her compensable injury had become medically stationary. We hold that Hartford is entitled to its statutory share of the proceeds.

FINDINGS OF FACT

In January 1988 claimant sustained a compensable injury when she slipped on a wet floor while performing her work activities as an administrator for a nursing care center. She filed an 801 claim, listing her injured body parts as the left knee and right hip.

In February 1988, Hartford Insurance, as insurer for claimant's employer, accepted the claim as a nondisabling injury. Since no medical bills had yet been received for the injury, Hartford reserved the right to contest whether any future medical bills were for services directly related to the injury.

In March 1988 claimant sought treatment from Dr. Iatesta, chiropractor. Iatesta diagnosed pelvic subluxation complex, sacroiliac sprain, compensatory "L/S S/S," and sprain/strain of the elbow. Noting that claimant's condition was not medically stationary, Dr. Iatesta released claimant for regular work.

Claimant continued to work and receive treatments from Dr. Iatesta. Her low back and right leg pain continued. In June 1988, Dr. Brett, neurosurgeon, performed an examination at Dr. Iatesta's request. X-rays and a CT scan disclosed minor degenerative changes, mild disc bulging, and some facet hypertrophy in the L4-5 area. Diagnosing discogenic back discomfort, Dr. Brett recommended that claimant continue her treatments with Dr. Iatesta, utilize a weight loss program, and participate in abdominal and back strengthening exercises.

On August 30, 1988, Dr. Iatesta reported that claimant was not released for work nor was she medically stationary. Attributing claimant's limitations to "increased debilitating pain and muscle spasm," Dr. Iatesta anticipated that claimant would be able to return to work by September 6, 1988.

On September 16, 1988, Dr. Iatesta released claimant to "part-time" work as of September 19, 1988. Iatesta emphasized that claimant's work should not interfere in her participation in a reconditioning program. In addition, Dr. Iatesta limited claimant's lifting to no more than 20 pounds and restricted her standing and sitting activities.

On September 19, 1988, claimant was involved in an off-work motor vehicle accident. Her vehicle was struck broad side by an "18-wheeler" and pushed approximately 200 yards into a bridge guard rail. Claimant was transported to the hospital, examined, and released. Thereafter, claimant's mid and lower back pain increased.

In November 1988, First Northwest Health (FNH) performed an independent medical examination. They concluded that claimant's thoracic complaints were medically stationary prior to the September 1988 accident, but that her low back complaints were not. Thus, FNH opined that the accident was the primary cause of claimant's thoracic complaints and had "apparently worsened" claimant's low back condition. Determining that claimant could return to regular duties but that her condition was not medically stationary, FNH recommended a "more aggressive exercise program or work hardening program."

In November 1988, claimant also returned to Dr. Iatesta, who had last examined claimant prior to the September 1988 accident. Noting that claimant was neither medically stationary nor had she

attained "maximum medical improvement prior to [the September 1988 accident]," Iatesta reported that claimant's treatments would continue. Until claimant's low back condition reached its pre-September 1988 accident level, Dr. Iatesta further explained that claimant's "PIP carrier" (rather than Hartford) would be billed.

In December 1988, Dr. Iatesta completed a physical capacity evaluation for claimant's vocational consultant. Recommending that claimant continue her chiropractic therapy as needed, Iatesta reported that claimant could perform modified work for 3 to 4 hours daily.

In January 1989, Dr. Iatesta concluded that claimant had sustained an aggravation of her low back condition due to the September 1988 accident. Although her condition was not medically stationary at the time of the accident, Iatesta stated that it "was not far from that state." Dr. Iatesta further noted that claimant had been released to modified work. Finally, Dr. Iatesta opined that "[t]he time loss which she has incurred since the MVA should not be the Hartford's responsibility in that it derives from the material worsening of her condition and not entirely from the on the job injury."

In March 1989, Dr. Iatesta reported that claimant's "overlay aggravation to her low back injury [caused by the September 1988 accident] is nearly resolved." Consistent with this opinion, Dr. Iatesta further stated that claimant's treatments had been primarily billed to her PIP carrier. Iatesta predicted that claimant would "shortly be at pre-accident status regarding the low back portion of her 9/16/88 injuries."

In May 1989, a Referee approved a settlement between claimant and Hartford which resolved claimant's pending hearing request. The hearing request had pertained to claimant's objection to Hartford's termination of her temporary total disability benefits (TTD). Hartford had terminated these benefits after receiving Dr. Iatesta's January 1989 report which suggested that Hartford should not be responsible for claimant's benefits.

Pursuant to the settlement, Hartford agreed to retroactively resume claimant's TTD and to continue processing claimant's claim as statutorily required. The settlement further provided that "Claimant acknowledges that carrier shall have a lien against the proceeds of any third party recovery claimant may secure on account of her subsequent motor vehicle accident pursuant to ORS 656.576 et seq."

In October 1989, FNH performed another independent medical examination. Although it was difficult to isolate whether the January 1988 compensable injury or the September 1988 motor vehicle accident were the major cause of her current symptoms, FNH concluded that the accident apparently caused a worsening of her lower back. Determining that claimant could return to her regular work and that her condition was medically stationary, FNH rated her impairment from her injuries as minimal.

In November 1989, Dr. Donkle, M.D., basically agreed with the report from First Northwest Health. Claimant had last treated with Dr. Donkle in June 1989. Donkle opined that claimant would not suffer permanent impairment as a result of the September 1988 accident, but that she might continue to experience minor difficulties until February or March 1990. Thereafter, Donkle concluded that further problems would not be "directly attributed to her motor vehicle accident." Finally, Dr. Donkle remarked that claimant "definitely did have a significant injury and although it wasn't a bony injury it was more ligamentous and muscle it took her a significantly long time to recover."

Shortly thereafter, Dr. Donkle reexamined claimant. Following that examination, Donkle retracted his prediction that claimant would not suffer permanent impairment as a result of the accident. Although continuing to concur with most of First Northwest Health's report, Dr. Donkle rated claimant's back and shoulder girdle impairment (directly related to her accident) as minimal to moderate.

On November 16, 1989, Dr. Iatesta also agreed with First Northwest Health's report with one exception. Stating that claimant may have more than a minimal impairment, Iatesta referred claimant to Dr. Segur for an evaluation.

On November 29, 1989, Hartford requested the issuance of a Determination Order. Noting that it had paid claimant temporary disability from August 1, 1988 through November 19, 1989, Hartford listed a total of $26,535.88 in TTD payments. In addition, Hartford reported $3,592.82 in medical costs.

A Determination Order issued on December 5, 1989. Claimant was awarded TTD from August 1, 1988 through November 7, 1989. A 7 percent ($2,240) unscheduled permanent disability award was also granted.

Claimant requested a hearing concerning the Determination Order. In February 1990, claimant and Hartford reached a settlement. In return for an additional 15 percent unscheduled permanent disability award, claimant's hearing request was dismissed.

In September 1990, Hartford requested a status report from the third party insurer. Hartford provided a list of its claim costs totalling $31,083.20. These expenses were composed of $24,217.14 in temporary disability (September 19, 1988 - December 3, 1989), $5,639.64 in permanent disability, and $1,226.42 in medical benefits (post 9-19-88 motor vehicle accident).

Claimant retained legal counsel to pursue a cause of action for negligence against the driver of the other vehicle and his employer. She subsequently filed a complaint seeking, at a minimum, $8,827.91 in medical expenses and $12,000 in lost wages. Claimant also sought undetermined amounts for future medical expenses and noneconomic damages.

An arbitration hearing concerning claimant's complaint was held in September 1991. In October 1991, an arbitrator awarded $7,700 in special damages and $13,600 in general damages. Thereafter, with Hartford's approval, claimant and the third party settled claimant's action for $30,000. When claimant refused to recognize Hartford's lien, claimant petitioned the Board for resolution of the dispute.

Dr. Donkle, Dr. Iatesta, and claimant's physical therapist have submitted several bills to claimant's private carrier. Outstanding balances concerning these bills remain.

In August 1992, Dr. Iatesta offered additional comments concerning claimant's condition and its relationship to her compensable injury and the September 1988 motor vehicle accident. Had the accident not occurred, Iatesta speculated that claimant might have been medically stationary within 30 days of the motor vehicle accident. Without the effects of the accident, Iatesta predicted that claimant would have been permanently restricted from bending and lifting over 20 pounds. Unable to differentiate between the low back impairment attributable to the two injuries, Iatesta could "only say that [claimant] would have had some permanent partial impairment from the on the job injury."

Dr. Iatesta further reported that he had treated claimant's mid/upper back and neck. These services had been billed to claimant's private carrier, who currently had an outstanding balance of $1,253. Iatesta noted that approximately $1,322 had been charged to Hartford for claimant's low back treatments, which had been fully paid. Regardless of claimant's September 1988 motor vehicle accident injuries, Iatesta stated that these treatments would have been necessary.

Statutory portions of the $30,000 settlement proceeds have already been distributed to claimant's attorney (for fees and litigation costs) and to claimant (for his statutory 1/3 share). The remaining balance of settlement proceeds ($12,831.66) has been held by claimant's attorney pending resolution of this dispute.

The September 19, 1988 motor vehicle accident aggravated claimant's compensable condition. Because of this aggravation, Hartford was required to provide additional benefits between October 18, 1988 through November 7, 1989. A distribution of the third party settlement proceeds in accordance with ORS 656.593(1) is "just and proper." Inasmuch as the aforementioned TTD exceeds $12,831.66, Hartford is entitled to recover the remaining balance of settlement proceeds.

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). However, a paying agency is entitled to receive a share of any third party recovery only to the extent that it has been obligated to pay additional benefits for the aggravated condition. Dooley, supra; Mary E. Bigler, 44 Van Natta 752 (1992); Oscar L. Compton, 44 Van Natta 288 (1992); Calina Neathery, 43 Van Natta 2374 (1991).

Here, claimant's compensable low back condition was reaching a medically stationary status when the September 1988 motor vehicle accident occurred. The accident aggravated her low back condition. According to Dr. Iatesta, claimant's treating chiropractor, if not for the accident, claimant's condition would likely have become medically stationary within 30 days of the September 19, 1988 accident. In light of such a conclusion, we find that, beginning October 18, 1988, temporary disability paid by Hartford would not have been provided but for the September 1988 accident.

Claimant contends that Hartford should not be permitted to recover temporary disability paid beyond January 4, 1989. As support for her contention, she relies on Dr. Iatesta's March 1989 report. At that time, Dr. Iatesta noted that claimant had again been released to modified work as of January 4, 1989. In addition, Dr. Iatesta predicted that claimant would shortly return to her pre-September 1988 motor vehicle accident status.

Notwithstanding this work release and prediction, Dr. Iatesta also concluded that claimant's condition was not medically stationary. Moreover, Dr. Iatesta agreed with the "medically stationary" assessment provided by First Northwest Health (and concurred in by Dr. Donkle), which eventually culminated in the Determination Order finding of a November 7, 1989 medically stationary date. In light of such circumstances and particularly considering Dr. Iatesta's conclusion that claimant's condition would have been medically stationary in October 1988 but for the September 1988 motor vehicle accident, we find claimant's assertion that her post-January 4, 1989 temporary disability was not attributable to the accident to be unpersuasive.

Consequently, we conclude that temporary disability paid to claimant from October 18, 1988 through November 7, 1989 (her eventual medically stationary date) was provided as a direct result of the September 1988 motor vehicle accident. Inasmuch as Hartford was required to provide this additional compensation due to this accident, we hold that it is entitled to recover these costs to the extent possible from claimant's third party settlement.

Hartford's $24,217.14 lien for temporary disability extends from September 19, 1988 through December 3, 1989. We have found that it is entitled to receive reimbursement for such benefits paid between October 18, 1988 and November 7, 1989. Thus, the exact monetary amount of lienable temporary disability compensation paid by Hartford is unclear. Nevertheless, since most of the $24,217.14 expenses are lienable, it is apparent that Hartford's claim costs for temporary disability benefits exceed the $12,831.66 remaining balance in settlement proceeds.

Accordingly, Hartford is entitled to the remaining balance of the settlement proceeds. In light of this conclusion, it is not necessary for us to determine whether those portions of Hartford's lien which pertain to medical expenses and permanent disability benefits are recoverable.

As a final matter, claimant argues that Hartford's "just and proper" share of the settlement proceeds should be calculated in a manner that accounts for several unpaid medical bills and outstanding private carrier liens which pertain to the September 1988 motor vehicle accident. We have consistently held that the distribution scheme for third party recoveries pertains to three specific entities; i.e., claimant's attorney, claimant, and the paying agency. Manual A. Ybarra, 43 Van Natta 376 (1991); Steven B. Lubitz, 40 Van Natta 450 (1988). In other words, we have reasoned that there is no statutory provision for third party disbursements to physicians, medical service providers, or private carriers. Id. Consistent with the aforementioned holdings, we decline claimant's request to reduce Hartford's lien on such a basis.

Furthermore, in essence, claimant is advocating a position that is available to any party in a dispute involving the distribution of a third party settlement; i.e., it would be more equitable to order a distribution that results in her receipt of a larger portion of the third party settlement (albeit to satisfy bills from other non-workers' compensation creditors and lienholders). Such an argument has been consistently rejected because of our conclusion that, in the long run the results of a disbursement

scheme inconsistent with the statutory distribution formula would be random, standardless, and, thus, inequitable. John C. Adams, 40 Van Natta 1794 (1988), aff'd mem Liberty Northwest v. Adams, 97 Or App 587 (1989); Delores M. Shute, 41 Van Natta 1458, 1460 (1989); Chris A. Meirndorf, 41 Van Natta 962 (1989). As reasoned in Shute, as the prosecutor in a third party action, the claimant is in the best position to make an informed and reasoned decision concerning the viability of the action and the propriety of any settlement offer. Likewise, the claimant is in the optimum position to determine whether a particular recovery will satisfy her statutory obligations, whether those obligations arise from within or outside the workers' compensation system. In accordance with this rationale, we reject claimant's petition to reduce Hartford's share of the settlement proceeds.

In conclusion, we find that Hartford is entitled to the remaining balance of settlement proceeds as its "just and proper" share of the third party recovery. Therefore, claimant's attorney is directed to disburse the $12,831.66 remaining balance to Hartford.

IT IS SO ORDERED.

September 29, 1992 Cite as 44 Van Natta 1854 (1992)

In the Matter of the Compensation of
DONALD L. GRANT, Claimant
WCB Case No. 92-00704
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Charles Cheek (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Albany Retirement Center, Inc. (Albany), a noncomplying employer, requests review of Referee Nichols' approval of a stipulation between the SAIF Corporation (as claim processor for Albany) and claimant in which SAIF rescinded its denial of claimant's right plantar fascitis condition and accepted the claim. Asserting that claimant's condition is not work-related, Albany objects to the settlement.

In essence, Albany is contesting SAIF's authority to enter into a stipulation without Albany's knowledge and approval. However, we have previously held that, as the statutory processing agent for a noncomplying employer, SAIF is authorized to enter into stipulations on the employer's behalf. See Jerry J. Johnson, 43 Van Natta 2758, 2759 (1991).

Furthermore, pursuant to ORS 656.054(1), a noncomplying employer has 90 days from the date the Director refers the claim to SAIF to object to the claim. Inasmuch as Albany did not request a hearing within 90 days of the November 2, 1991 Director's noncompliance order or the November 6, 1991 referral of the claim to SAIF, Albany's objection to the claim is untimely. See ORS 656.054(1).

Accordingly, we affirm the Referee's approval of the parties' stipulation.

In reaching this conclusion, we note that Albany has also requested a hearing contesting compensability of the claim and SAIF's acceptance. (WCB Case No. 92-06280). That hearing request was dismissed by Referee Lipton based on Albany's alleged failure to appear at the scheduled hearing. This date, we have vacated that dismissal order and remanded the case to Referee Lipton for further proceedings. Notwithstanding our decision in WCB Case No. 92-06280, our review in this case is limited to Albany's appeal of the Referee's stipulated order. For the reasons previously discussed, we affirm Referee Nichols' approval of the parties' stipulation.

Inasmuch as Albany 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), we find that a reasonable attorney fee for claimant's counsel's services on review is $500, to be paid by SAIF on behalf of Albany.

IT IS SO ORDERED.

In the Matter of the Compensation of
DONALD L. GRANT, Claimant
WCB Case No. 92-06280
ORDER ON REVIEW (REMANDING)
Malagon, et al., Claimant Attorneys
Julene Quinn (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Albany Retirement Center, Inc. (Albany) a noncomplying employer requests review of Referee Lipton's order which dismissed its request for hearing concerning the acceptance of claimant's injury claim by the SAIF Corporation. Claimant cross-requests review seeking an attorney fee for services at the hearing level. On review, the issues are the propriety of the dismissal and attorney fees. We remand.

FINDINGS OF FACT

A hearing was requested by an April 15, 1992 letter from John A. Sleutel, president of Albany. The apparent basis of the hearing request was an objection to the compensability of the claim and to the SAIF Corporation's acceptance of claimant's injury claim. (Tr. 2-3). At the time of the July 30, 1992 scheduled hearing, claimant and his attorney, as well as counsel for SAIF, as the processing agent for Albany, were present.

Neither Mr. Sleutel nor counsel representing Albany were present at the hearing. Claimant, joined by SAIF, moved to dismiss Albany's hearing request with prejudice. The Referee granted the motion in a July 31, 1992 Order of Dismissal.

By letter dated August 10, 1992, Mr. Sleutel, on behalf of Albany, objected to the dismissal of his hearing request for his failure to appear. Sleutel asserted that another representative of Albany was present at the hearing. This letter was received by the Board on August 12, 1992 and treated as a request for Board review of the Referee's order.

On August 13, 1992, the Referee mailed a letter to Mr. Sleutel stating that because no one purporting to represent Albany responded at the hearing, the dismissal would stand.

CONCLUSIONS OF LAW AND OPINION

Unjustified failure of a party or a party's representative to attend a scheduled hearing is a waiver of appearance. OAR 438-06-071(2). If the party that waives appearance is the party that requests the hearing, the referee shall dismiss a request for hearing unless extraordinary circumstances justify postponement or continuance of the hearing. Id.

A postponement requires "a finding of extraordinary circumstances beyond the control of the party or parties requesting the postponement." OAR 438-06-081. We have interpreted these rules to allow a party alleging extraordinary circumstances the opportunity to establish such circumstances for the purpose of justifying his or her nonappearance at a scheduled hearing. We have previously held that a Referee must consider a motion for postponement of a hearing even after an order of dismissal has been issued. Vincent G. Jacoban, 42 Van Natta 2866, 2867 (1990); Mark R. Luthy, 41 Van Natta 2132 (1989).

In Isabel Mendoza-Lopez, 43 Van Natta 2765 (1991), a noncomplying employer failed to appear at hearing to challenge SAIF's acceptance, on its behalf, of an injury claim. Although the referee allowed the hearing on compensability to proceed, the noncomplying employer's failure to appear effectively operated as a rejection of his challenge to the compensability of the claim. The noncomplying employer in Mendoza-Lopez requested review of the referee's order and offered an explanation for his failure to appear. We treated the employer's request for review as a motion for reconsideration of the referee's finding that the employer's failure to appear was unjustified and constituted a waiver of appearance. Consequently, we remanded to the Referee to rule on the employer's motion.

We likewise find that the present case must be remanded to the Referee. Here, the Referee found Albany's failure to attend the scheduled hearing constituted a waiver of appearance and dismissed the hearing request. In response to the Referee's ruling, Albany submitted a letter objecting to the dismissal of the hearing and asserting also that another representative of Albany was present at the time of hearing. It is unclear from the record whether anyone representing Albany was actually present at the hearing as Albany asserts. In any event, we interpret Albany's letter objecting to the dismissal as a motion for postponement of the hearing. In such cases, we have concluded that the referee is in the best position to rule on a motion for postponement. See, e.g., Ray Eaglin, 43 Van Natta 1175 (1991).

Accordingly, the Referee's order dated July 31, 1992 is vacated. This matter is remanded to Referee Lipton to determine whether Albany failed to appear at the hearing. If so, the Referee shall further determine whether that failure to appear at the scheduled hearing was justified. In making this determination, the Referee shall have the discretion to proceed in any manner that will achieve substantial justice to all parties.

If the Referee determines that Albany did appear at the hearing, a further hearing will be convened concerning the merits of Albany's hearing request. If the Referee finds that Albany failed to attend the hearing and its failure was justified, a further hearing concerning the merits of Albany's hearing request will be convened. If the Referee finds that Albany's failure was not justified, the Referee shall reinstate his prior Order of Dismissal.

In light of this holding, it would be premature for us to address claimant's request for an attorney fee award. That issue should be considered by the Referee on remand.

IT IS SO ORDERED.

September 29, 1992 Cite as 44 Van Natta 1856 (1992)

In the Matter of the Compensation of
CHARLES W. HERMO, Claimant
WCB Case Nos. 91-10217 & 91-03117
ORDER ON REVIEW
Rick W. Roll, Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of Referee Spangler's order which set aside its denial of compensability of claimant's cervical condition. In its brief, the employer argues that the Referee erred by overruling its objection to certain testimony. On review, the issues are evidence and compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's 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

Evidence

At hearing, on direct examination by claimant's attorney, the following exchange took place:

"Q. (By claimant's attorney) Dr. Keizer says in his deposition and in his reports that you were unclear about when your neck problems started. Is that correct?

"A. (By claimant) Yeah. I believe he did say something at the later part of the hearing. I brought -- I brought it up several times, but he kind of -- just like he wanted to pass the buck on it for some reason."

At hearing, the employer's attorney objected to this response by claimant, characterizing it as hearsay and a statement of claimant's opinion of Dr. Keizer's state of mind. (Tr. 15-16). The Referee sustained the hearsay objection as to what the doctor said; however, he overruled the objection to the statement by claimant. On review, the employer continues to object to the statement "just like he wanted to pass the buck on it for some reason." The employer requests that this statement be stricken from the record.

ORS 656.283(7) provides 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." We review evidentiary rulings for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991). We do not find that the Referee abused his discretion by allowing claimant's statement into the record.

Compensability

The Referee analyzed compensability of the claim under ORS 656.005(7)(a)(B), concluding that claimant had established that his current cervical condition is compensable and setting aside the employer's partial denial of that condition. We agree that, insofar as the employer denied the occurrence of a compensable cervical injury on August 22, 1986, that denial should be set aside. However, we find that, insofar as the employer denied the compensability of the current cervical condition, that denial should be upheld.

Compensability is determined under ORS 656.005(7)(a)(B) when "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." Subsequent to the Referee's opinion, we have construed the statute as requiring a two-step determination. See Bahman N. Nazari, 43 Van Natta 2368, 2370 (1991). First, claimant must prove that the industrial accident is a material contributing cause of disability or need for treatment. Id. Then, in determining the compensability of the resultant condition, claimant must prove that the compensable injury, rather than the preexisting condition, is the major contributing cause of his disability or need for treatment. Id.

Here, the August 22, 1986 work incident severely injured claimant's lumbar spine; the employer accepted the lumbar injury. The question presented now is whether this 1986 incident also injured claimant's cervical spine. We find that the record establishes that it did.

Dr. Keizer, treating orthopedist, opined that, if claimant had cervical complaints within two days of the date of the incident, the incident also injured claimant's cervical spine via an aggravation of his preexisting spondylosis. (Exs. 52A-16 through -18, -30, -31, -38). The employer, relying on reports from the Orthopedic Consultants, argues that: (1) claimant did not have any cervical complaints until 10 days to two weeks following the work incident; and (2) the appearance of cervical complaints after the work incident was a coincidence, solely related to the preexisting cervical spondylosis. We defer to Dr. Keizer based on the fact that he has an extensive treatment history with claimant since January 1987. We also find that Dr. Keizer had a greater awareness of the timing of the onset of cervical complaints.

Dr. Keizer explained that the severity of the lumbar injury, which caused greater and more prolonged symptoms and eventually resulted in two surgeries, effected claimant's ability to recall precisely when the cervical complaints began. (Ex. 52A-8). Dr. Keizer carefully questioned claimant as to when his cervical pain began and reported that it began "either two days, one week, or possibly two weeks from the time of his initial injury." (Ex. 50). Claimant testified that he had neck discomfort on the morning following the work accident. (Tr. 12-14). Furthermore, in an accident report that claimant signed two days after the work incident, he reported that he strained his back and neck. (Ex. 2). Based on this record, we find that claimant suffered neck pain at least within two days following the work incident. Thus, based on Dr. Keizer's opinion, we find that claimant sustained a compensable cervical injury as a result of the August 1986 work incident.

However, all of the medical evidence acknowledges that claimant has a preexisting cervical spondylosis condition. Dr. Keizer opined that the cervical injury aggravated the preexisting cervical spondylosis. (Exs. 52A-30, -31, -38). We find that Dr. Keizer's opinion establishes that the preexisting

condition combined with the injury. The record establishes that the cervical complaints began within two days of the work incident resolved about a month later. Since that time, claimant has suffered from intermittent flare-ups of cervical pain which are treated with physical therapy. The question is whether the work injury is the major contributing cause of these intermittent flare-ups, the resulting condition.

The Orthopedic Consultants opine that all of claimant's cervical complaints are caused by the preexisting cervical spondylosis condition. (Ex. 51). Dr. Keizer was unable to say whether the injury was the major contributing cause of the continuing flare-ups. (Exs. 52A-20, -21, -24, -31). Although no "magic words" are necessary, we find that Dr. Keizer gives no opinion as to the effect of the work injury on the flare-ups.

Therefore, we conclude that claimant proved a compensable cervical injury. However, we further conclude that the compensable injury combined with the cervical spondylosis and that the record does not establish that the major contributing cause of the resulting condition is the compensable injury. Thus, claimant's current cervical condition is not compensable. We note, parenthetically, that claimant is not precluded from establishing that any future disability and/or need for treatment is related, in major part, to the compensable cervical injury and is, therefore, compensable. Rita M. Parke, 44 Van Natta 1612 (1992).

The Referee set aside the employer's denial in its entirety 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 August 22, 1986 cervical injury, in the amount of $1,750. 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 November 27, 1991 is affirmed in part and reversed in part. That portion of the Referee's order which set aside the self-insured employer's denial insofar as it denied compensation for claimant's resulting cervical condition is reversed and that part 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 August 22, 1986 cervical injury, in the amount of $1,750. The remainder of the order is affirmed.

In the Matter of the Compensation of
JUANITA C. HICKERSON, Claimant
WCB Case No. 91-09584
ORDER ON REVIEW
Coughlin, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Hooton and Brazeau.

Claimant requests review of Referee Crumme's order that: (1) found that her claim had not been prematurely closed; and (2) affirmed an Order on Reconsideration that had awarded temporary disability compensation through the October 25, 1991 medically stationary date. On review, the issues are premature closure and temporary disability compensation. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the last two sentences of paragraph 9 and substitute the following for the Referee's ultimate findings of fact.

On October 25, 1990, further material improvement in claimant's accepted condition was reasonably expected from the passage of time.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that the Evaluation Section properly determined claimant to be medically stationary as of October 25, 1990 and at the November 21, 1990 claim closure, based on Dr. Hendricks' statement that claimant was medically stationary in his closing examination report. Claimant contends that Dr. Hendricks anticipated claimant becoming medically stationary after completion of a 60-day break-in period at work. We agree.

In deciding this matter, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 2. Claimant did not become medically stationary prior to July 1, 1990. We accordingly analyze this matter under ORS 656.268 as amended.

It is claimant's burden to establish that she was not medically stationary on the date of closure. Scheuning v. J. R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (1987). "Medically stationary" means that no further material improvement would reasonably be expected from either medical treatment or the passage of time. ORS 656.005(17). We accordingly evaluate claimant's condition and the reasonable expectation of improvement as of the November 21, 1990 date of closure.

The resolution of the medically stationary date is primarily a question for competent medical experts. Harmon v. SAIF, 54 Or App 121, 125 (1985). At the time of closure, claimant had been examined by Dr. Hendricks, on referral from Dr. Camp, who had performed claimant's June 1990 discectomy and fusion surgery. Dr. Hendricks stated that claimant "is now medically stationary. She is not in need of any further formal treatment [which] would be palliative and not curative." However, he continued:

> "I believe that the patient can return to gainful employment without restrictions, but I would suggest that she initially be given an opportunity to have periods of rest and that she not immediately go into jobs which will require her to work with her head constantly in the flexed position and that she not be required to do work activities which require her working over her head or above shoulder level, and no heavy lifting, stooping, etcetera. I believe after a satisfactory break-in period of say 60 days that she should be able to return to gainful employment without restrictions. I feel that she probably could return to her job as a CNA." (Ex. 36-5).

Dr. Camp concluded that claimant was medically stationary on October 26, 1990, but recommended that she follow Dr. Hendricks' return-to-work restrictions for 60 days, and then return to regular work after 60 days. (Ex. 37). Dr. Donofrio, claimant's attending physician, stated only that he agreed with Dr. Hendricks' conclusions. (Ex. 38).

Although the three physicians agree with Dr. Hendricks' assertion that claimant was medically stationary on or about October 25, 1990, we interpret Dr. Hendricks' conclusion to be based primarily on his assessment that claimant required no further curative medical treatment. In our view, his comments that she would be capable of returning to work without restriction after a 60-day break-in period indicate that he expected claimant's back condition to improve with the passage of time. Each physician was in agreement with Dr. Hendricks' assessment regarding the need for a 60-day break-in period. Accordingly, we find that there was a reasonable expectation on the part of all three physicians that claimant would material improve with the passage of time. In addition, Dr. Hendricks' comments relating to claimant's ability to return to work in 60 days involves a prediction for the future, which does not establish medically stationary status. See Volk v. SAIF, 73 Or App 643, 646 (1985); Edward B. Castro, 44 Van Natta 362 (1992). Consequently, we find that the claim was prematurely closed.

Temporary Disability Compensation

Because we find that the claim was prematurely closed, it is unnecessary for us to address the temporary disability compensation issue.

ORDER

The Referee's order dated December 18, 1991 is reversed. The Determination Order is set aside as premature. The claim is remanded to the insurer 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, payable directly to claimant's attorney.

In the Matter of the Compensation of
MERIDEE A. KAIEL, Claimant
and CULTURAL HOMESTAY INSTITUTE, Noncomplying Employer
WCB Case Nos. 91-03467, 90-12953 & 90-20519
ORDER ON RECONSIDERATION
Schwabe, et al., Attorneys
Wallace & Klor, Attorneys
James Dodge (Saif), Defense Attorney

Claimant has requested reconsideration of our August 12, 1992 Order on Review. In our order, we concluded that claimant was a subject worker but that her right ring finger injury claim was not compensable because it occurred while she was engaged in a recreational activity primarily for her personal pleasure. On August 31, 1992, we abated and withdrew our order to allow the noncomplying employer an opportunity to respond. The employer has responded, cross-requesting reconsideration. Having received the employer's response, we proceed with our reconsideration.

On reconsideration, claimant first contends that her participation in the optional bumper car ride was within the course and scope of her employment. She argues that she acted within the course and scope of her employment when she participated in the roller skating activity and that there is no rational basis for distinguishing the roller skating activity from the bumper car activity. We disagree. The record indicates that, as an optional activity, the bumper car ride was discouraged by the employer whereas the roller skating activity was a sponsored activity. (Ex. 1-6; Tr. 98, 152, 182). Moreover, the bumper car ride was not part of the program budget or itinerary sent to Japan for approval. (Tr. 98). Claimant appears to argue that, because the employer allowed her to participate in the scheduled roller skating activity and did not forbid the optional bumper car ride, it acquiesced in the ride and, therefore, her participation in the ride was in the course and scope of her employment. However, whether the employer acquiesced in the activity is relevant to the unitary work-connection analysis, not to whether claimant's participation in the ride was primarily for her personal pleasure. See Rogers v. SAIF, 289 Or 633 (1980); Mellis v. McEwen, Hanna, Gisvold, 74 Or App 574 (1985); Michael W. Hardenbrook, 44 Van Natta 529 (1992).

Claimant next contends that there is no support for the Board's conclusion that she could not supervise the students and ride the bumper cars at the same time. She states that our conclusion overlooks the fact that, while she rode the bumper cars, two parents remained outside the ride to supervise. Moreover, she argues that, had the need arisen, her participation in the ride would have facilitated supervision, instead of hindering it. We do not find this argument persuasive. First, the record establishes that the parents were there as drivers, not as supervisors. (Tr. 240). Furthermore, claimant was one of only two supervisors for a group of twenty-one teenagers, only eight of which rode the bumper cars. (Tr. 231; Ex. A). Both the record and common sense indicates that her participation in the bumper car ride would prevent her from being mobile enough to respond to supervision problems created by students either on that ride or in other parts of the amusement park. (Tr. 258-259).

Claimant further contends that the fact that claimant enjoyed her work, i.e. the bumper car ride, does not support the Board's conclusion that claimant's primary purpose in riding the bumper cars was her personal pleasure. In support of her contention, she argues that there is no evidence that more than half of claimant's motivation in riding the bumper cars was to have fun. She points to her testimony on cross-examination as proof that her primary purpose was to supervise the students. However, we interpret the portion of the transcript cited by claimant to refer to her primary purpose for being at the amusement park, not to her primary purpose in riding the bumper cars. Moreover, based on our de

novo review of the record, we find that claimant's only stated purpose in participating in the ride was to have fun. (Tr. 64).

Claimant also contends that Board erred in relying on Michael W. Hardenbrook, supra and argues that we should have found claimant's claim compensable under Ester E. Edwards, 44 Van Natta 1065 (1992). However, we find that the facts in the present case are consistent with our findings in Hardenbrook and distinguishable from the facts in Edwards. In Hardenbrook, the claimant injured his knee while playing basketball. We found that the benefit to the employer, improved moral and energy, was incidental in view of the claimant's testimony that he played because it was fun, he loved to play and it was an enjoyable way to relieve stress, tension and monotony. Consequently, we concluded that the claimant's injury was not compensable because he was injured while engaging in activities "primarily" for his personal pleasure.

On the other hand, in Edwards we concluded that the claimant's knee injury, which occurred during an employer-sponsored volleyball game, was compensable. Noting that the claimant testified that she did not participate in the game for exercise and had not played for many years, we found that her primary purpose in playing volleyball was "because the staff was doing it together." Consequently, we found that the claimant's primary purpose for participating in the volleyball game was not her personal pleasure and, analyzing the facts under the unitary "work-connection" test, concluded that her injury arose out of and in the course of her employment.

Here, we found that claimant's only stated purpose in riding the bumper cars was to have fun. The fact that she went on the ride three times and paid for the rides out of her own funds underscores this finding. Moreover, even assuming arguendo, that one of her reasons for participating in the ride was to supervise the students and that her presence on the ride indirectly prevented supervision problems, we find, as we did in Hardenbrook, that the benefit to the employer was incidental in view of claimant's testimony that she rode the bumper cars for fun.

Additionally, claimant argues that Town & Country Chrysler v. Mitchell, 113 Or App 434 (1992) also supports compensability of her claim. We find that case inapplicable. First, it was decided under a higher standard pursuant to former ORS 656.005(7)(b)(B), which excluded only activities "solely" for the worker's personal pleasure. Moreover, as noted by the Mitchell court, that holding does not apply in cases, such as here, where the activity is employee organized, voluntary and only indirectly beneficial to the employer.

In its cross-request for reconsideration, the employer contends that, in determining that claimant was a subject worker, we erred in failing to apply the traditional "right to control test." Citing Bernards v. Wright, 93 Or App 192 (1988), the employer argues that the Board is required to consider the right to control factor and that the evidence here does not establish that it had or exercised sufficient right to control to designate claimant an employee. We agree that control is an essential ingredient in determining whether claimant is a subject worker. However, where as here, the employer had the right to control in some respects but not in others, it is permissible for us to turn, as we did in our Order on Review, to other relevant factors set forth in the "relative nature of the work test." See Woody v. Waibel, 276 Or 189, 196 (1976). Consequently, we conclude that the employer's argument was adequately addressed in our August 12, 1992 order.

Accordingly, our August 12, 1992 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our August 12, 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
LYNNE R. MACKEY, Claimant
WCB Case No. 90-22295
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of those portions of Referee Hoguet's order which: (1) set aside its denial of claimant's occupational disease claim insofar as it pertained to acute irritant injury, balance disorder resulting from brain stem dysfunction, mild organic brain syndrome and simple phobia; and (2) awarded a $25,000 attorney fee under ORS 656.386(1). In her brief, claimant contests those portions of the Referee's order that: (1) upheld the insurer's denial insofar as it pertained to balance disorder caused by her preexisting inner ear condition; and (2) declined to assess a penalty and related fee for an allegedly unreasonable failure to timely provide discovery. On review, the issues are compensability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Preliminary Matter

Claimant moves to strike claimant's arguments raised in her respondent's brief, asserting that the issues of compensability of claimant's worsened inner ear condition and untimely discovery are not properly before the Board inasmuch as claimant did not cross-request for review on those issues. We disagree.

The Board may address any issues considered by the Referee, even in the absence of a cross-request for review on the issues. Destael v. Nicolai Company, 80 Or App 596, 600-01 (1986); William E. Wood, 40 Van Natta 999, 1001 (1988).

Here, untimely discovery and compensability of claimant's worsened inner ear condition, as well as the compensability of claimant's acute irritant injury, balance disorder resulting from brain stem dysfunction, mild organic brain syndrome and simple phobia, were issues considered by the Referee. Although the insurer's appellant's brief raised only the issue decided adverse to it, claimant's respondent's brief raised the remaining issues. Therefore, even though claimant did not file a cross-request for review concerning the untimely discovery and compensability of claimant's worsened inner ear condition issues, we may consider those issues on review. Also see Artemio Vergara, 43 Van Natta 1253, 1254-55 (1991). The motion to strike is denied.

Compensability

We adopt the Referee's "Conclusion and Opinion" on the issue of compensability.

Penalties and Attorney Fees - Discovery

We adopt the Referee's conclusions on the issue of penalty/attorney fee for the insurer's allegedly unreasonable failure to provide discovery in a timely fashion.

Attorney Fees - At Hearing

The Referee awarded claimant an assessed fee of $25,000 for prevailing at hearing against the insurer's denial. On review, the insurer argues that the fee is excessive. We find the Referee's attorney fee award to have been reasonable.

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." OAR 438-15-010(4).

The hearing in this matter was conducted over five days. In addition, claimant's attorney attended four depositions held on four separate days. The record reflects that claimant's counsel submitted a lengthy, well-reasoned written closing argument following the hearing. Claimant's counsel's affidavit of hours establishes that counsel devoted 172 hours of attorney time and 32.25 hours of staff time at the hearing level.

This matter involves a complex toxic exposure claim with resultant physical, cognitive and psychiatric disorders. Because the claim was found to be compensable, claimant will be entitled to necessary medical care for her conditions.

The record evidences that both counsel are skilled and each demonstrated that skill during the hearing. Fourteen 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 that the fee awarded by the Referee on the compensability issue was appropriate.

Attorney Fees - On Review

After applying the aforementioned factors to this case on review, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issues raised by the insurer is $3,000, 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, affidavit of hours, the complexity of the occupational disease issues and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review concerning her defense of the Referee's attorney fee award. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia Inc., 80 Or App 233 (1986). In addition, claimant is not entitled to an attorney fee for her unsuccessful efforts regarding the "balance disorder/inner ear condition" compensability issue and the discovery issue.

ORDER

The Referee's order dated September 6, 1991 is affirmed. For services on review concerning the insurer's "compensability" appeal, claimant's counsel is awarded a reasonable assessed fee of $3,000, payable by the insurer. The remainder of the Referee's order is affirmed.

September 29, 1992 Cite as 44 Van Natta 1863 (1992)

In the Matter of the Compensation of
JO W. ORMAN, Claimant
WCB Case Nos. 90-20297 & 91-03270
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of that portion of Referee Holtan's order that upheld the SAIF Corporation's denial of her occupational disease claim for a psychological condition. On review, the issue is compensability.

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

Among the requirements for establishing the compensability of her mental stress claim, claimant must prove by clear and convincing evidence that employment conditions were the major contributing cause of the mental disorder or its worsening. See ORS 656.802(2), (3)(d); Penny L. Wilson, 44 Van Natta 85, 87 (1992). As the Referee stated, to be "clear and convincing," the truth of the facts asserted must be "highly probable" and "free from confusion." Riley Hill General Contractor v. Tandy Corp., 303 Or 390, 407 (1987).

Here, claimant relies on Dr. Lowery's opinion that claimant's "mental and physical collapse was caused by her employment exposure" with the employer. (Ex. 44-2). He also opined that "[claimant's] job injuries, their aggravations, marginal rehabilitation treatment and ongoing battles to obtain her injured worker benefits are ... solely responsible for her current psychological condition." (Id.)

On the other hand, Dr. Turco attributed claimant's psychological difficulties to her husband's unemployment status and significant personal financial stressors. (Ex. 36-8). Later, by check-the-box response, Dr. Turco agreed that the major contributing cause of claimant's psychiatric condition is her personal stressors, including difficulties with her husband, his unemployment status, financial stress, and other family stressors, rather than her 1976 industrial injury or her work with the employer. (Ex. 40-2). Additionally, Dr. Simpson noted chronic stressors due to financial problems and the inability of claimant and her husband to care for their large house. (Ex. 30-2). Dr. Simpson did not relate claimant's psychological problems to her work exposure with the employer. (Id.)

It is undisputed that claimant has had psychological difficulties since 1977, for which she treated with Dr. Lowery. Dr. Lowery attributed those difficulties to the 1976 industrial injury with a previous employer and the subsequent re-injury and/or aggravation. (Ex. 44-1). However, his letter dated January 18, 1979, also indicates that claimant experienced regressive psychological episodes following stressful experiences within her family involving her husband, daughter or son. (Claim No. OD41705 Ex. 21-1).

The record shows that during her employment with the employer, claimant continued to have family problems. Ms. Wyse, claimant's supervisor, testified that claimant complained of marital problems and spoke of leaving her husband. (Tr. 62-63). Ms. Wyse recalled that claimant had to take time off from work to settle banking problems because she was in the process of leaving her husband. (Tr. 63). Ms. Price, claimant's co-worker, testified that claimant described her husband as "insane" in a serious manner. (Tr. 79).

Where the medical evidence is divided, we generally give greater weight to the attending doctor's opinion. See Weiland v. SAIF, 64 Or App 810, 814 (1983). In this case, however, we are persuaded not to give greater weight to Dr. Lowery's opinion. Dr. Lowery feels that claimant's psychological problems, including her need for hospitalization, are entirely related to employment factors, including her previous work injury. (See Ex. 44-2). While he acknowledged that claimant has marital problems and has undergone "considerable family strife," he concluded that they have not resulted in any decompensation in her mental state. (Id.) Based on our review of the aforementioned evidence, however, we do not find Dr. Lowery's opinion to be persuasive. There are numerous references to marital, family and financial problems which have plagued claimant for many years. As discussed above, claimant more recently described her husband as "insane" and indicated her intent to leave him.

Under these circumstances, we decline to accept Dr. Lowery's opinion that personal factors did not contribute to claimant's psychological difficulties. Rather, we are more persuaded by Dr. Turco's thorough, well-reasoned opinion. Under these circumstances, we conclude that it is not "highly probable" that the work exposure with the employer is the major contributing cause of claimant's psychological condition and resulting need for treatment. Accordingly, claimant's mental stress claim is not compensable.

ORDER

The Referee's order dated September 18, 1991, as reconsidered on October 25, 1991 is affirmed.

In the Matter of the Compensation of
TERRY L. TAYLOR, Claimant
WCB Case No. 91-10896
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of that portion of Referee McCullough's order which awarded claimant a $750 assessed attorney fee under ORS 656.386(1) for his counsel's services in obtaining compensation without a hearing. In his respondent's brief, claimant contends that he is entitled to a penalty-related attorney fee under ORS 656.382(1), in addition to the penalty and associated fee awarded by the Referee under ORS 656.262(10), for SAIF's unreasonable delay in paying temporary disability. On review, the issue is attorney fees.

We affirm and adopt the order of the Referee with the following modifications and supplementations.

The Referee awarded an insurer-paid attorney fee for claimant's counsel's efforts in obtaining the payment of temporary disability and a medical bill without a hearing. We agree that claimant's counsel was instrumental in obtaining the payment of these benefits. Nevertheless, to receive a carrier-paid fee under ORS 656.386(1), claimant must prevail against a denial of compensability. See Short v. SAIF, 305 Or 541, 545 (1988); Euzella Smith, 44 Van Natta 778 (1992). Thus, to the extent that the Referee's attorney fee award pertained to the temporary disability payments, such an award was not authorized under ORS 656.386(1) because claimant's aggravation claim from which those benefits emanated had been accepted not rejected. See Charles L. Smith, 41 Van Natta 75 (1989) (No assessed attorney fee under ORS 656.386(1) when the insurer unilaterally terminated temporary disability under an accepted claim).

However, medical bills are required to be paid or denied within the required time period. See Billy J. Eubanks, 35 Van Natta 131 (1983). Furthermore, 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); Euzella Smith, supra.

Here, SAIF had neither accepted nor denied claimant's medical bill within 90 days of its receipt of the bill. Thereafter, claimant requested a hearing seeking payment of the bill. In light of such circumstances, SAIF's eventual payment of the bill prior to the scheduled hearing constitutes a rescission of its "de facto" denial of the bill. Consequently, claimant's attorney is entitled to a fee under ORS 656.386(1) for services pertaining to this 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 concerning the medical bill issue is $750, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue as demonstrated by the record, the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney might go uncompensated. Consequently, we affirm the Referee's $750 insurer-paid attorney fee award.

Finally, claimant argues that he is entitled to a penalty-related attorney fee under ORS 656.382(1), in addition to the penalties assessed by the Referee under ORS 656.262(10), for SAIF's unreasonable delay in paying compensation. However, since the factual basis for the penalty under ORS 656.262(10) is identical to the factual basis for awarding an attorney fee under ORS 656.382(1), claimant is not entitled to an attorney fee under ORS 656.382(1) in addition to the penalty assessed under ORS 656.262(10). See Nicolasa Martinez, 43 Van Natta 1638 (1991), aff'd, Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

Inasmuch as attorney fees are not compensation, claimant is not entitled to an attorney fee for his successful defense of the Referee's attorney fee award on Board review. State of Oregon v. Hendershott, 108 Or App 584 (1991); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated January 31, 1992 is affirmed.

September 29, 1992 Cite as 44 Van Natta 1866 (1992)

In the Matter of the Compensation of
ARNOLD G. WHEELER, Claimant
Own Motion No. 66-0332M
AMENDED OWN MOTION ORDER
Vick & Gutzler, Claimant Attorneys
Saif Legal Department, Defense Attorney

The Board issued its own motion order in this matter on September 18, 1992. The order was incorrectly listed as an Own Motion Order. Since this is not a final order, it should have been listed as an Interim Own Motion Order.

Accordingly, our September 18, 1992, order is abated and withdrawn. As amended herein, we adhere to and republish our September 18, 1992, order in its entirety.

IT IS SO ORDERED.

September 30, 1992 Cite as 44 Van Natta 1866 (1992)

In the Matter of the Compensation of
MARGARET J. CURTIS, Claimant
WCB Case No. 91-06150
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Davis' order which: (1) upheld the insurer's denial of her low back strain claim; and (2) declined to assess a penalty and related attorney fee for the insurer's allegedly unreasonably and untimely denial of the claim. 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 for the last sentence in the first paragraph on page 2 of the order, with the following supplementation.

At the time of the October 12, 1990 work incident, claimant experienced immediate severe pain in her back. (Tr. 8-9). The injury was reported to the employer on the day it occurred. (Tr. 9, 25; Ex. 1).

Hospital chart notes from October 15, 1990 to November 15, 1990 indicate claimant had low back pain and tenderness. (Ex. 1A). She was diagnosed with lumbar strain. (Ex. 2). Dr. McKinstry treated claimant on six occasions for the strain. (Tr. 12).

Claimant was taken off work and then returned to work with restrictions. (Ex. 2A). Prior to her injury she had no restrictions. (Tr. 22). At the time of the hearing, claimant had returned to regular work and was working 10-hour shifts. (Tr. 23).

The October 12, 1990 work incident was a material cause of claimant's immediate disability and need for medical treatment. It was not, however, the major contributing cause of her current ongoing low back condition.

CONCLUSIONS OF LAW AND OPINION

Compensability

The insurer's May 14, 1991 letter denied compensability of claimant's lumbar strain. (Ex. 3). At hearing, the insurer raised the defense that claimant has a preexisting condition and that her injury was not the major contributing cause of her need for treatment and disability. (Tr. 5). The Referee concluded that claimant, in fact, has a preexisting back condition. He also concluded that while claimant's October 12, 1990 work incident resulted in pain and was established by medical evidence supported by objective findings, it was not the major contributing cause of claimant's current low back condition. We agree with the Referee's conclusions. However, the Referee did not address the threshold issue of whether the October 12, 1990 work incident was a material contributing cause of claimant's lumbar strain. Consequently, we address it here.

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 treatment. See ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). Claimant's disability or need for medical treatment must be established by medical evidence supported by objective findings. See Suzanne Robertson, 43 Van Natta 1505 (1991). Then, if it is determined that there is a preexisting condition and that condition combined with the injury to cause or prolong disability or the need for treatment, claimant is entitled to disability compensation and treatment if the injury was the major contributing cause of the resultant disability or need for medical treatment. ORS 656.005(7)(a)(B).

As to the first prong of the test, claimant credibly testified that she developed low back pain on October 12, 1990 after testing the brine in a tank in which the brine level was low. She stated that she reached down and almost went head first into the brine tank. (Tr. 8-9). Claimant's feet came off the ground, pulling her back, and she felt immediate and severe pain in her low back. (Tr. 9, 11-12). She wanted to leave work because of the pain but was directed by "Dennis," an onsite supervisor, to continue to work. (Id.). Claimant finished her shift and reported the incident to the employer that day. (Tr. 10; Ex. 1). She sought medical treatment the following Monday and was diagnosed with "lumbar strain." (Tr. 11; Ex. 2). Chartnotes from the Good Samaritan Clinic repeatedly refer to claimant's low back strain as being employment related. (Ex. 2A). Dr. McKinstry expressly opined that claimant's injury "occurred at work." (Ex. 2). While the medical evidence is sparse, we conclude that it is sufficient to establish that the October 12, 1990 work incident was a material contributing cause of claimant's immediate disability and need for medical treatment. Accordingly, we conclude that claimant has satisfied the first prong of the test by establishing a compensable injury. See Mark N. Wiedle, supra.

We next consider whether claimant's compensable injury has combined with her preexisting back condition to cause or prolong her disability or need for treatment, and whether the injury is the major contributing cause of the resultant disability or need for medical treatment. ORS 656.005(7)(a)(B). As noted above, we agree with the Referee's reasoning and conclusion that claimant has failed to establish that her injury is the major contributing cause of her ongoing disability and need for medical treatment and adopt that portion of the Referee's order. Accordingly, although claimant has established the occurrence of a compensable injury on October 12, 1990, her current disability is not compensable under this claim.

Therefore, the insurer's denial is set aside to the extent it denied the compensability of claimant's lumbar strain. In addition, the insurer's denial is upheld to the extent that it denied compensation for claimant's current back disability and need for treatment.

Penalties and Attorney Fees

The Referee concluded that, given claimant's preexisting condition, the insurer's denial was not unreasonable. We agree and adopt that portion of the Referee's order. Additionally, while the Referee found that the insurer's denial was significantly late, he did not assess a penalty for unreasonable resistance to the payment of compensation because there was no compensation due. We agree with the Referee that a penalty is not available to claimant under ORS 656.262(10) because there was no

compensation due between the date when an acceptance or denial should have issued and the date of the denial.

However, ORS 656.382(1) also provides for an assessed attorney fee when an insurer engages in conduct, which constitutes an unreasonable resistance to the payment of compensation, even though there are no amounts then due upon which to base a penalty. See Nicolasa Martinez, 43 Van Natta 1638 (1991), aff'd Martinez v. Dallas Nursing Home, 114 Or App 453 (1992). In the present case, the October 12, 1990 claim was not denied until May 14, 1991, more than 90 days after the claim was filed. (Exs. 1, 3). By failing to timely respond to the claim, the insurer delayed the ultimate resolution of the compensability issue. As noted by the Referee, the insurer offered no explanation for the delay at hearing. Consequently, we find that its failure to respond to claimant's claim was an unreasonable resistance to the payment of compensation, and an attorney fee pursuant to ORS 656.382(1) is assessed on this basis. Richard J. Stevenson, 43 Van Natta 1883 (1991); Steve Chambers, 42 Van Natta 524 (1990); Cindi A. Cadieux, 41 Van Natta 2259 (1989).

Attorney Fee Award

Claimant is entitled to an assessed attorney fee for finally prevailing in part against 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 $1,000, to be paid by the insurer. In addition, after considering the aforementioned factors, we find that a reasonable fee on the untimeliness issue under ORS 656.382(1) is $500. In reaching these conclusions, we have particularly considered the time devoted to the case, as represented by the hearing record and claimant's appellate briefs, the complexity of the issues, and the value of the interest involved, in light of our conclusion that claimant's current condition is not compensable.

ORDER

The Referee's order dated October 15, 1991 is reversed in part and affirmed in part. That portion of the insurer's denial which denied the compensability of claimant's lumbar strain condition is set aside, and the injury claim is remanded to the insurer for processing according to law. The insurer is assessed an insurer-paid attorney fee of $500 for its unreasonable resistance to the payment of compensation. The remainder of the Referee's order is affirmed. For services rendered at hearing and on review concerning the compensability issue, claimant's counsel is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
RANDY L. DARE, Claimant
WCB Case Nos. 91-05505 & 91-00099
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Debra Ehrman (Saif), Defense Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Liberty Northwest Insurance Corporation (Liberty Northwest) requests review of those portions of Referee Gruber's order that: (1) set aside its denial, on behalf of Lou A. Surcamp Logging, of claimant's claim for a current right carpal tunnel syndrome (CTS) condition; and (2) upheld the SAIF Corporation's denial, on behalf of Jim's Auto and RV Repair, a noncomplying employer (NCE), of claimant's new occupational disease claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee found that Liberty Northwest failed to prove that responsibility for claimant's right CTS condition shifts to SAIF, the later insurer, because claimant's work activities for the noncomplying employer were not the major cause of his current condition. Liberty Northwest contends that the Referee erred legally and factually. We disagree.

Claimant has an accepted right CTS condition with Liberty Northwest. Therefore, responsibility for that condition remains with Liberty Northwest, unless claimant sustained a new compensable occupational disease involving the same condition while SAIF was on the risk. ORS 656.308; Donald C. Moon, 43 Van Natta 2595 (1991); Rodney H. Gabel, 43 Van Natta 2662 (1991). To shift responsibility to SAIF, Liberty Northwest must prove that work activities for the NCE were the major contributing cause of a pathological worsening of his right CTS condition. ORS 656.802(2); Donald C. Moon, supra.

Here, it is undisputed that claimant's current right CTS problems involve the same condition which Liberty Northwest accepted. The question is whether claimant's work activities with SAIF's insured were the major cause of the recurrent right CTS. See Rodney H. Gabel, supra.

In this case, the opinions of Drs. Karasek and Jewell, treating physicians, may be read to support a conclusion that claimant's work activities for the NCE caused a worsening of his right CTS condition. However, because we agree with the Referee that these opinions are not persuasive due to lack of adequate reasoning, we adopt the Referee's reasoning in this regard, which appears on page 7 of the Opinion and Order, with the following supplementation.

Although we generally assign greater weight to the opinions of treating physicians, we do not do so when there are persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). Here, we find such reasons.

Dr. Karasek performed numerous nerve conduction studies in response to claimant's bilateral wrist and hand complaints since 1987. On June 26, 1991, Karasek opined, based on these studies, that claimant's right CTS had worsened in the summer and fall of 1990. (Ex. 51). However, Karasek later contradicted himself, stating that claimant's March 1988 studies were actually worse than the ones performed in the summer and fall of 1990. (Ex. 52-26). He further stated that his opinion that the condition worsened was based on claimant's September 1990 clinical presentation as well as nerve conduction studies which he described as "consistent" with a "subtle worsening." (Ex. 52-27). In our view, Karasek's opinion is inconsistent over time and lacks a reliable factual basis to judge its validity. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980). Consequently, it is unpersuasive and we do not rely on it. See Somers v. SAIF, 77 Or App 259 (1986).

Dr. Jewell relied on Karasek's interpretation of the nerve conduction studies in recommending surgery for claimant. (Ex. 53-5-6; 53-20-21). To the extent that Karasek's opinion concerning the import of the studies is unpersuasive, so is Jewell's opinion, which is based in material part on Karasek's reading of the study results.

In addition, we find Jewell's opinion regarding causation to lack persuasive force, even insofar as it is does not depend on Karasek's nerve conduction studies. In reaching this conclusion, we note that, on January 10, 1991, Jewell stated that he could not "necessarily identify the major contributing factor for [claimant's] present condition, as there appears to be a hand disease process which existed prior to his starting employment as a mechanic [under SAIF's coverage]." (Ex. 39). On February 22, 1991, Jewell acknowledged that the exact etiology of claimant's right CTS "is difficult to arrive at with certainty." He opined that the claimant's work activities activities as a mechanic caused the preexisting CTS to become symptomatic "to the point that conservative, non-operative management has not been successful, and that surgery will be indicated." (Ex. 44; see Ex. 48). Dr. Jewell last saw claimant on April 24, 1991. (Ex. 53-17). On June 10, 1991 Jewell opined that "due to the worsening of the underlying carpal tunnel syndrome, surgery is indicated." (Ex. 48).

On June 20, 1991, Dr. Jewell first opined that claimant's later employment was the major cause of a worsening in the right CTS condition, stating that claimant's problem involved more than a waxing and waning of that condition. (Ex. 49; see Ex. 50). Even if Jewell meant to say that claimant's work for

the NCE was the major cause of claimant's current condition, (rather than merely its purported worsening) (see e.g., Exs. 53-21 & 53-24), Jewell failed to adequately explain how he overcame his prior difficulty in identifying the etiology of claimant's right hand problems. (See Ex. 53-18). In attempting to do so, Jewell first stated that his changed opinion was based on claimant's complaints and Karasek's interpretation of the nerve tests. (Ex. 53-18). Later, he stated that his most recent opinion regarding causation was based on "further history." (Ex. 53-28). Eventually, Jewell admitted that the "further history" to which he referred was available to him when he stated that he could not identify the major contributing cause of claimant's right CTS. (Ex. 53-29-30. Under these circumstances, we find Jewell's opinion to be insufficiently explained and therefore, unpersuasive. Accordingly, we decline to rely on it. See Somers v. SAIF, supra.

In this case, medical reports consistently refer to claimant's "continuing," "ongoing," "chronic" and "persistent" right hand problems, after the claim with Liberty Northwest was closed. (See Exs. 33, 34, 34A-2, 35, 37, 39, 45). There is no persuasive evidence indicating that claimant's later work exposure was the major cause of a pathological worsening in right CTS condition. Consequently, on this record, we conclude that responsibility for the current condition remains with Liberty Northwest.

ORDER

The Referee's order dated January 23, 1992 is affirmed.

In the Matter of the Compensation of
SANDRA L. MASTERS, Claimant
WCB Case No. 90-07279
ORDER ON REVIEW
McKeown, et al., Claimant Attorneys
Donald Dickerson, Defense Attorney

Reviewed by Board Members Moller and Neidig.

The self-insured employer requests review of those portions of Referee Mongrain's order that: (1) awarded claimant additional temporary total and temporary partial disability; and (2) assessed penalties and attorney fees for allegedly unreasonable claim processing. In her respondent's brief, claimant contends that she is entitled to additional temporary total disability. On review, the issues are temporary disability, 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 Facts" and "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Applicable Law

In deciding this matter, the Referee concluded that claimant was entitled to temporary partial disability benefits from January 13 to July 1, 1990. The Referee based his finding on the fact that, prior to the July 1, 1990 effective date of Senate Bill 1197, claimant was entitled to temporary disability benefits until she was both medically stationary and released to work by her attending physician. Further, prior to July 1, 1990, a chiropractor could be defined as an attending physician with no limitations on authorization of temporary disability benefits. However, the Referee concluded that after the July 1, 1990 law became effective, claimant's chiropractor could no longer be defined as an attending physician and authorize temporary disability benefits. Accordingly, under this analysis, the Referee found that claimant's temporary disability benefits would cease on July 1, 1990. We modify.

We conclude that, regardless of which law is applicable, claimant is entitled to temporary partial disability benefits upon leaving her job.

Under the law in existence prior to July 1, 1990, claimant was entitled to temporary disability compensation until her claim was closed, or she was both medically stationary and released by the attending physician to return to regular work. Former ORS 656.268(1) and (2); Fazzolari v. United Beer Distributors, 91 Or App 592 (1988); Carmen Gusman, 42 Van Natta 425 (1990). Under former OAR 436-60-030(3) and (4), the employer was required to pay temporary partial disability benefits until one of three events occurred: (1) claimant's attending physician returned claimant to temporary total disability status; (2) claimant's temporary partial disability benefits were terminated by a Determination Order or Notice of Closure in accordance with former ORS 656.268; or (3) temporary partial disability benefits had been paid for two years.

Here, claimant was not physically able to perform her regular work following her injury. She was released to modified work, but has never been released to "full duty." Therefore, when claimant terminated her job, she still had not been released to regular work, nor had she been found medically stationary. Thus, under the law in existence prior to July 1, 1990, claimant was entitled to temporary partial disability benefits when she stopped working due to personal reasons. See former ORS 656.268(1) and (2); Fazzolari, supra; Vincent L. Thompson, 42 Van Natta 1921 (1990).

Under the current law which became effective July 1, 1990, amended 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.

Accordingly, temporary disability is not due and payable under amended ORS 656.262(4)(b) if two requirements are met. First, the insurer must have requested from the worker's attending physician verification of the worker's inability to work resulting from the claimed injury or disease. Second, the physician must be unable to verify the worker's inability to work. The statute is applicable if these two requirements are met unless the worker has been unable to receive treatment for reasons beyond the worker's control.

At the outset, we note that there is no evidence that claimant was unable to receive treatment for reasons beyond her control. Further, the present issue involves a "continuing" authorization of benefits, i.e., an authorization provided prior to July 1, 1990. In this regard, amended ORS 656.262(4)(b) provides a method to deal with such "continuing" authorizations. Yet, there is no evidence in the record that the employer requested verification of the worker's inability to work resulting from the claimed injury or disease. Finally, although claimant left work for personal reasons, at the time that she left, her physician had not released her to regular work, nor had he retracted his finding that she was only capable of modified work.

Based on these facts, we find that pursuant to amended ORS 656.262(4)(b), temporary disability compensation was due and payable when claimant stopped working due to personal reasons. Also see Joel O. Sandoval, 44 Van Natta 543 (1992).

The employer contends that, because the law in effect as of July 1, 1990 does not grant chiropractors the right to authorize temporary disability and no medical doctor authorized such benefits for claimant, she is not entitled to any temporary disability benefits. We are not persuaded by the employer's argument.

As a result of changes to the law pursuant to the 1990 amendments, the Department acknowledged that there may be workers eligible for or receiving time loss benefits based on the authorization of a physician who, on July 1, 1990, would become a non-attending physician. Therefore, to keep any such affected workers to a minimum, the Department issued the following requirement:

> "Insurers and Self-Insured Employers shall provide written notification to all workers with a deferred or accepted claim who are currently receiving medical services from a non-attending physician of the changes which go into effect on July first. The

> notice shall advise how the changes will affect the worker and what the worker will need to do to continue to receive time loss benefits or compensable medical services. Also, the notice must contain the insurer's contact person the worker may call to answer any questions about the changes. With the notice the insurer must include a list of 'attending physicians' in the worker's city. The worker shall be given 30 days written notice before any benefits may be terminated. A copy of the Notice to the worker must also be sent to the worker's medical service provider and to the worker's attorney, if represented." See Department Of Insurance and Finance Bulletin No. 215 (June 8, 1990). (Emphasis supplied).

In the present case, there is no evidence in the record that the required notice was provided to claimant. In circumstances such as these, i.e., where the employer failed to comply with the Department's notification process regarding how changes occurring after July 1, 1990 will affect the worker, we do not find that the employer may then unilaterally terminate temporary disability benefits on the basis that claimant has not complied with the new law.

We conclude that under both current and former law, the employer was not entitled to unilaterally terminate claimant's temporary partial disability benefits merely because she terminated her job for personal reasons. Nor do we find that the employer was entitled to unilaterally terminate claimant's temporary partial disability benefits due to the fact that, as of July 1, 1990, the physician who had authorized time loss was no longer an "attending physician." Consequently, claimant's temporary partial disability benefits shall continue until this compensation can be properly terminated in accordance with law. Accordingly, we modify the Referee's order to award temporary partial disability from January 13, 1990 until these benefits can be lawfully terminated.

Temporary Total Disability

Claimant contends that she is entitled to temporary total disability when she resigned from her light duty position. She alleges that the effects of commuting exacerbated her condition and rendered her temporarily totally disabled at the time of, or following, her resignation. We disagree.

On April 4, 1990, in a "check-the-box" letter to claimant's counsel, Dr. Wehinger stated that he had authorized time loss retroactive to January 23, 1990. (Ex. 29). Inasmuch as this "fill-in-the-blank" response is conclusory and fails to discuss claimant's prior activities or history, we do not find it to be persuasive in regard to claimant's inability to work. Moreover, Dr. Wehinger has provided no opinion on claimant's light duty capabilities. Accordingly, we give his opinion little weight. Considering Dr. Gilliland's release to modified work and his awareness of claimant's relocation, as well as claimant's written resignation, we are not persuaded that claimant was totally disabled from performing gainful and suitable employment. Consequently, she is not entitled to temporary total disability.

Penalties and Attorney Fees

The Referee found that the employer unreasonably refused to pay compensation. Applying current ORS 656.262(10)(a), the Referee assessed a penalty equal to 25 percent of the amount of temporary disability benefits payable to claimant, with one half of the penalty to be paid to claimant and one half to her attorney. Further, the Referee held that the employer's failure to pay temporary disability benefits amounted to unreasonable resistance to compensation justifying a separate fee pursuant to ORS 656.382(1). We modify the penalty and reverse the separate attorney fee award.

In deciding this issue, the Referee applied the law as amended by Oregon Laws 1990 (Special Session), chapter 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.

Inasmuch as the employer was not authorized to terminate claimant's temporary partial

disability benefits under either the former or current law, we agree with the Referee that the employer's conduct was unreasonable. However, as a result of our decision that claimant's temporary partial disability should continue until lawful termination, the amount of the compensation "then due" upon which to base a penalty has not been limited to end on July 1, 1990. Consequently, the penalty shall be modified accordingly.

We reverse the Referee's award of a separate attorney fee. 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, there are amounts "then due" on which to assess a penalty under ORS 656.262(10). However, 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). The court has recently affirmed our decision. Martinez v. Dallas Nursing Home, 114 Or App 453 (1992). Accordingly, claimant is not entitled to a separate fee under ORS 656.382(1).

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 temporary disability issue is $500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant 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). Nor is claimant entitled to an assessed fee for services rendered on review concerning her entitlement to additional temporary total disability.

ORDER

The Referee's order dated March 29, 1991, as reconsidered May 10, 1991, is affirmed in part, modified in part and reversed in part. The Referee's temporary partial disability award is modified. Claimant is awarded temporary partial disability compensation commencing January 13, 1990 until this compensation can be lawfully terminated. Claimant's attorney is awarded 25 percent of this increased compensation. However, the total attorney fee award from claimant's compensation awarded by this order and the Referee's order shall not exceed $3,800. The penalty assessment shall be modified to include the additional compensation resulting from this order. In lieu of an attorney fee, claimant's attorney shall receive 50 percent of the penalty resulting from this order and the Referee's order. The Referee's separate attorney fee award of $1,600 is reversed. The remainder of the Referee's order is affirmed. For services on Board review concerning the temporary partial disability issue, claimant's attorney is awarded $500, to be paid by the employer.

In the Matter of the Compensation of
KENNETH E. MILLER, Claimant
WCB Case No. 91-11107
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Tooze, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Myers' order that: (1) set aside its denial of claimant's low back injury claim; and (2) declined to address its denial of claimant's current low back condition. On review, the issues are scope of review and compensability. We affirm in part and modify in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Scope of review

On July 31, 1991, the insurer denied claimant's claim, based on its belief that "the major contributing cause of any need for medical care and/or disability to [claimant's] back is non work related." (Ex. 6). With claimant's consent, the Referee allowed the insurer to amend its denial post-hearing. The amended denial admits "that there was an episode at work where [claimant] pushed a coach, after which [claimant] complained of back pain." (O&O p. 1). However, it denies "any disability or need for treatment following that episode," on the basis that the major contributing cause of any such disability or treatment was claimant's preexisting condition, rather than the work incident. (Id).

The parties' post-hearing correspondence indicates that they intended and agreed to place the amended denial before the Referee for decision concerning the compensability of all claimant's low back disability and treatment. Under these circumstances, we conclude that the Referee should have addressed the compensability of claimant's "current condition." Accordingly, inasmuch as the compensability of claimant's current condition is raised on review, we address it pursuant to our de novo review authority. See Harold W. Bynum, 44 Van Natta 165, 166 (1992).

Compensability

The insurer argues that we should reconsider and disavow our order in Bahman M. Nazari, 43 Van Natta 2368 (1991), or, alternatively, that claimant has not carried his burden under ORS 656.005(7)(a)(B). We decline to reconsider Bahman M. Nazari, supra, and proceed to the merits in the present case.

In its amended denial, the insurer concedes that the coach-pushing work incident on July 12, 1991 actually happened. The occurrence of that incident is not seriously disputed on review. The question is whether any of claimant's subsequent disability and treatment for his low back is compensable.

In Bahman M. Nazari, supra, we held that, in cases involving preexisting conditions, the compensability of a claim involves a two-part test. First, claimant must establish that he suffered an accidental injury arising out of and in the course of employment, which was a material contributing cause of his 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 his injury remained the major contributing cause of his resulting disability. ORS 656.005(7)(a)(B); Bahman M. Nazari, supra. We have held that claimant bears the burden of proof under the statute. See Tony L. Rivord, 44 Van Natta 1036 (1992); Lareta C. Creasey, 43 Van Natta 1735, 1737 (1991). Bertha M. Gray, 44 Van Natta 810 (1992). See also Thomas Porter, 43 Van Natta 2599 (1991) (claimant jailed to carry his burden of proving major contributory causation).

Here, we agree with the Referee's conclusion that claimant established the compensability of his July 12, 1991 work injury. In reaching this conclusion, we rely on Dr. Lord's emergency room report which recorded the injury as claimant described it and authorized time loss and medical treatment for claimant's low back. (See Ex. 3). We are also persuaded by claimant's testimony regarding the sudden onset of severe low back pain following the coach-pushing incident. On these bases, we conclude, as did the Referee, that claimant's July 12, 1991 work injury is compensable as it was a material cause of his immediate disability and need for treatment. See Mark N. Wiedle, supra.

We next consider whether claimant has carried his burden concerning the claimed disability and medical services for his current low back condition.

Claimant testified that low back and leg symptoms from a prior off-work injury did not resolve prior to the coach-pushing incident. Dr. Lord indicated that evidence of such preexisting symptoms would affect his opinion concerning the causation of claimant's current condition. (See Ex. 11). Under these circumstances, we find that claimant had a preexisting low back "condition" which, in combination with the work injury, contributed to claimant's subsequent disability and need for treatment. See ORS 656.005(7)(a)(B). Therefore, insofar as claimant's preexisting condition combined with his compensable injury, "the resultant condition is compensable only to the extent that the compensable

injury is and remains the major contributing cause of the disability or need for treatment." Id. In addition, considering the off-work and work injuries and the apparent causal interaction between them, we find that the causation issue is a complex medical question requiring expert medical opinion for its resolution. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986); Uris v. Compensation Department, 247 Or 420 (1967).

In this case, the only expert evidence regarding causation is provided by Dr. Lord, who examined claimant in the hospital emergency room on July 15, 1991. Lord opined that claimant's work injury was the major cause of his need for emergency room treatment. (See Exs. 10, 11-32; 11-34). However, his opinion is confined to claimant's condition on July 15, 1991. Neither Lord nor any other expert offered an opinion concerning the etiology of claimant's low back problems subsequent to the emergency room visit. In the absence of persuasive medical evidence regarding the etiology of claimant's current condition, we conclude that claimant has not carried his burden, under ORS 656.005(7)(a)(B). See Uris v. Compensation Department, supra. Accordingly, we conclude that, although claimant has established that he suffered a compensable injury on July 12, 1991, he has not proven entitlement to compensation for disability or treatment subsequent to that initial emergency room visit, which was compensable. See Tony L. Rivord, supra, (the initial medical treatment was compensable; the subsequent treatment was not).

Claimant is entitled to an assessed attorney fee for partially 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 of the initial injury claim is $500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 10, 1992 is modified in part and affirmed in part. That portion of the Referee's order that did not address the insurer's denial of claimant's current condition is modified. The insurer's denial is upheld to the extent it denied claimant's current condition. The remainder of the order is affirmed. For his services on review concerning the compensability of the initial injury claim, claimant's counsel is awarded an attorney fee of $500, payable by the insurer.

In the Matter of the Compensation of
GRACE M. NYBURG, Claimant
WCB Case No. 91-12452
ORDER ON REVIEW
Charles G. Duncan, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Quillinan's order that upheld the insurer's denial of her aggravation claim for her 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 exception of her finding that the May 21, 1991 Order on Reconsideration was claimant's last award or arrangement of compensation.

The August 30, 1990 Determination Order was claimant's last award of compensation.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant had not proven a worsening since the May 21, 1991 Order

on Reconsideration which awarded claimant an additional 1 percent unscheduled permanent disability. Although we agree that claimant's aggravation claim is not compensable, we conclude that the Determination Order, not the Order on Reconsideration, was the last arrangement or award of compensation.

Subsequent to the Referee's order, we concluded that the logical point from which to measure claimant's worsening is at his last opportunity to be heard with respect to his condition. See Frank L. Stevens, 44 Van Natta 60 (1992); Larry H. Erbs, 42 Van Natta 98 (1990). Furthermore, we have recognized that it is possible that a worker could worsen subsequent to his last opportunity to present evidence at hearing, but prior to the Referee's issuance of an order. Larry H. Erbs, supra; Joseph R. Klinsky, 35 Van Natta 333 (1983). Therefore, in determining the date of the last award or arrangement of compensation, we reject an approach which could cut off a claimant's aggravation rights during the period between his last opportunity to present evidence on his current condition and a final order of the Board or appellate courts establishing claimant's compensation. Joseph R. Klinsky, supra.

Here, the May 21, 1991 Order on Reconsideration reconsidered claimant's "current condition" as of the date of the August 30, 1990 Determination Order. In doing so, only evidence presented up until the time of the Determination Order was considered. Thus, the Order on Reconsideration is analogous to a final order of the Board or appellate courts concerning a record that was developed at hearing. See Frank L. Stevens, supra. Accordingly, we conclude that the August 30, 1990 Determination Order, which the May 1991 order reconsidered, was claimant's last opportunity to present evidence of her current condition. Therefore, the August 1990 Determination Order was the last arrangement or award of compensation.

In the present case, the Referee alternatively found that, even if claimant's last award was the August 1990 Determination Order, claimant had failed to establish a worsening since that time. We agree with the Referee's Conclusions and Opinion regarding claimant's failure to prove a worsened condition. Accordingly, we adopt the Referee's alternative findings and conclusion on the issue of aggravation.

ORDER

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

In the Matter of the Compensation of
ANEATRA L. ROST, Claimant
WCB Case No. 90-15445
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Susan D. Ebner (Saif), Defense Attorney

Reviewed by Board Members Westerband, Moller and Gunn.

Claimant requests review of Referee Spangler's order that upheld the SAIF Corporation's denial of her left shoulder, back strain, gastritis, and stress injury claim. On review, the issue is course and scope of employment.

We affirm and adopt the order of the Referee. See SAIF v. Barajas, 107 Or App 73, 76 (1991) (whether claimant is "aggressor" is not the only criterion for determining "active participation").

ORDER

The Referee's order dated September 10, 1991 is affirmed.

Board Member Gunn dissenting.

I do not find any reason, based on the record, to reach the conclusions that the Referee did as adopted by the majority. The Referee was not persuaded that claimant sustained a compensable injury.

In reaching that conclusion, the Referee found that claimant was not a credible witness. The Referee based that finding on the substantive record, not on claimant's demeanor. Under the circumstances, the Board is equally competent to evaluate the substance of claimant's testimony. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

After conducting a review of the record, I do not find claimant's version of the events surrounding the work incident to lack reliability or credibility. Furthermore, since the medical evidence is consistent with claimant's version of the incident, I am persuaded that claimant's injury claim is compensable. See Jeannie L. Sheldon, 44 Van Natta 1670 (1992).

To begin, I address claimant's testimony as to what happened on February 24, 1990. Claimant testified that:

> "I walked -- I say nothing. I walked over to the kitchen sink. I washed the dishes, and then I -- Jim was sitting right -- I get Mrs. Swogert a granola bar every evening, and Jim was between the cupboard and him was there, and I said, Jim, will you excuse me; I'd like to get a bar. And he hollered at me, and he said, the G.D. bar is not for Mrs. Swogert; it's for the dog.
>
> "* * * * *
>
> "Then he wheeled around in that chair, and he come flying off that chair at me, and he come at me with two fingers to poke my eyes out, and I started backing up, and then he started grabbing in midair for me, and then he connected with me over here [my left shoulder] . . . and there's two built-in wall ovens, I got shoved right back into that and then held there and then down -- then I was pushed down onto the floor. . . And I said, this is it, Jim; this is it. And I didn't know if he was going to kick me or what he was going to do, so I stayed down there, and I just crawled out on all fours, and I got halfway down the hall and then I stood up and into the TV room I went and called 911." (Tr. 58-60).

Claimant's testimony on direct examination was consistent with her testimony upon cross-examination. Further, claimant gave the same testimony at a criminal proceeding a week prior. Moreover, her testimony is completely consistent with her report of the February 24, 1990 incident to her medical providers.

Specifically, claimant sought medical attention on February 27, 1990. Dr. Wiebe reported:

> "[Claimant] comes in because she was injured at work on the 24th of February. She works as a homemaker/housekeeper and the cook who is off and is mean towards people. She thinks he has some mental problems. He is 500 pounds. He attacked her and threw her against the wall, injured her low back and her left shoulder. . . " (Ex. 1)

Dr. Wiebe found objective findings of tenderness in the shoulder and low back. He found that her low back range of motion was somewhat restricted. Dr. Wiebe diagnosed, "shoulder strain and a low back strain." (Id).

On July 30, 1990, claimant was examined by Dr. Dinneen of Western Medical Consultants. Dr. Dinneen reported that:

> "[Claimant] dates the current problems to February 24, 1990. She was involved in a scuffle with a cook at a private home where they both worked. . . . "
>
> "* * * * *
>
> "[Claimant] appears to be a credible historian. She did, however, not until the last few seconds of the interview state that actually the problem had started many months before the February 24, 1990 incident and this mostly in the form of the cook reportedly hitting her with a door repeatedly." (Ex. 4).

On July 30, 1990, claimant was also examined by Dr. Bellville, psychiatrist of Western Medical Consultants. Dr. Bellville reported:

> "According to [claimant], she was assaulted by a fellow worker. The day of injury is listed as February 24, 1990, but in fact, she details a history of physical and verbal assaults over about a two-year period. . . . [Claimant] began working for her employer on June 1, 1986. She had difficulty with the first cook who worked there. The second one, the one that this situation involves, began working there about two years ago. She began having difficulty with him right from the start and the difficulties continued. She complained, she says, to her employer but to no avail. She continued working there in the difficult situation because she liked her job. She was taking care of an elderly woman by the name of Francis Swigert [sic]. The pay was good, she liked Mrs. Swigert, and she loved the home she was working in. She tolerated the situation with that cook until March 1990." (Ex. 5).

I note that this report is consistent with claimant's testimony at hearing. Further, it is consistent with the witnesses who testified for SAIF, who confirmed that claimant had complained to her employer, but nothing changed because of those complaints.

On July 30, 1990, claimant was examined by Dr. Heinonen, gastroenterologist, also of Western Medical Consultants. Dr. Heinonen reported:

> "[Claimant] states that she has had chronic problems with people where she was employed. She was evidently employed as a nurses' aide for Francis Swigert [sic] for the last three years. She has been under stress because of what she calls both verbal and physical harassment from a cook She states that on February 24, he attempted to poke her eyes out with his fingers, pushed her back against a wall, injuring her back and then pushed her to the floor. She subsequently called 911, and attempted to get him arrested." (Ex. 6).

There is nothing in the record which discounts claimant's version of the events that occurred. The only rebuttal to claimant's reporting comes from Mr. Dotten, the cook who allegedly assaulted claimant. I find, however, that Mr. Dotten's testimony, unlike claimant's, is not consistent. Therefore, I must find Mr. Dotten not a reliable historian and accordingly, discount his credibility as to his version of the events of February 24, 1990. I make these findings for the following reasons.

As to the February 24, 1990 incident, Mr. Dotten testified that he was in the kitchen and claimant wanted to get a granola bar. Mr. Dotten testified that he was sitting on a stool propped forward so that it was resting with the weight on the front two legs. Mr. Dotten then testified that:

> "She said, I want into the cupboard. And I said, I'm sorry; you want to feed that to Mrs. Swogert and Nellie, but it's mostly Nellie that you want to feed, and I'm sorry, Mrs. Swogert doesn't need it right now; wait 35 seconds and -- I mean, I was almost through with the grating the cheese. The next thing I remember, I was heading down grabbing the counter, as she had yanked the stool and with one foot kind of kicked the stool out, so I had lost balance and equilibrium. As I turned around, she had her fists up, and she threw her glasses off . . . and started punching me, and I just laughed. I mean, she's a very small lady, and she's punching me. I wasn't brought up that way; maybe she was. So she grabbed my hands -- or I mean, I grabbed her hands, rather, and I said, I don't believe this, and I just pushed her out of the kitchen. . . . " (Tr. 147-149).

Mr. Dotten testified that he did not fall to the floor, but rather his knee hit the floor and his buttocks hit the heel of his foot as his knee hit the floor. (Tr. 164).

I note that Mr. Dotten's testimony at hearing differs from his testimony at the criminal proceeding a week prior. At the criminal proceeding, Mr. Dotten testified that he fell to floor onto his buttocks. This is clearly inconsistent with his testimony at hearing, in which he elaborately described how he did not fall to the floor, but only to his knee.

Further, at the criminal proceeding, Mr. Dotten testified that it took "quite a while" for him to get back up. He indicated that because of his weight of 406 pounds, he would either need help getting

up off the floor or it would take him some time to get up from the floor by himself. (Ex. 8-52, 53). When questioned about what claimant was doing during this "quite a while" period in which he was struggling to get up off the floor, Mr. Dotten altered his testimony and stated that it only took him a "minute" to get up from the floor. Upon further, cross-examination, he testified that it only took him "30 seconds." Further, Mr. Dotten testified that it was after he got up from the floor that claimant began punching him. (Ex. 8-52, 53). However, he could not explain why a 52 year old woman, who is 5'2" and approximately 130 pounds would wait until a 400 pound man had stood up before allegedly punching him. Finally, Mr. Dotten testified that during the time he was on the floor, he did not know what claimant was doing, that he "really wasn't keeping track of her." (Ex. 8-53). However, Mr. Dotten also testified that during that time, she was right behind him, with her hands up, ready to go. (Id).

I question Mr. Dotten's testimony inasmuch as he has described the incident differently from one week to the next. Also, I question, how he could know what claimant was doing if his back was towards her and he was struggling to get up. Also, Mr. Dotten originally stated that he did not know what claimant was doing during that time.

Further, there is no explanation for how claimant strained her back and shoulder, if Mr. Dotten merely held her hands as he claims. Finally, at the workers' compensation hearing, Mr. Dotten was instructed by SAIF's attorney to say the same things that he had said in court a week earlier. (Tr. 174). However, Mr. Dotten testified at hearing that, "I don't even remember what I testified to last week." (Tr. 199).

I find this curious and note that Mr. Dotten does not need to remember what he testified to last week, he only has to remember the truth, and if there is a distinction between the two, I must question the credibility of his testimony. Further, even if Mr. Dotten is not indicating culpability, but merely stating that he does not remember the truth, then I must question his reliability for that reason.

Another matter that gives rise to my questioning Mr. Dotten's reliability, concerns his conversing about the hearing with another witness in the midst of the hearing. Mr. Dotten asserted that he only asked the witness whether his drinking habits had been put into question during the hearing. When asked whether that is all he asked the witness, Mr. Dotten replied, "yes". However, he added that, "I'm giving you probably a naive answer. I probably should have said, no, nothing happened." (Tr. 179). In other words, Mr. Dotten testified that he probably should have lied. Therefore, all subsequent testimony after that statement, I find questionable.

Based on the above facts and reasoning, claimant's testimony has not been rebutted. Her testimony is substantiated by evidence in the record. Mr. Dotten's testimony, however, has reasons for it to be questioned, or at the very least, discounted. Moreover, there is absolutely no evidence in the record which supports Mr. Dotten's testimony except his bare assertions. Accordingly, I would find that claimant has met her burden of proof.

Although I find no reason to consider the events prior to February 24, 1990 in assessing the compensability of claimant's claim, the Referee and the majority did. Therefore, I will discuss those matters and provide my own reasoning for each point.

The Referee found claimant's credibility lacking because of "the unusualness of and the number of the accusations" in the record. First, the same could be said of anyone who has been the victim of abuse. I would not discount the testimony of Anita Hill, Rodney King, the only survivor of Jeffery Dahmer, or the naval women of Tailhook for those reasons, although undoubtedly the same could be said in each of those circumstances. Thus, I also do not find such reasons to be persuasive in the present case. The essence of abuse is that it is "unusual," meaning not appropriate behavior or behavior that, if one is lucky, not experienced in our day to day encounters. Moreover, it usually does not occur publicly or with the luck of having witnesses. Rather, abuse occurs behind closed doors and/or unwitnessed. Also, by the time abuse is reported, the incidents of abuse are most always numerous, and not a single odd event. Furthermore, the accusations, by nature or number, do not discount claimant's credibility for the following reasons.

The Referee questioned claimant's credibility inasmuch as he found that she had accused Mr.

Mitch, the cook prior to Mr. Dotten, of poisoning her food. The Referee was further persuaded by Mr. Mitch, who denied having done any such thing.

The record establishes that claimant believed some substance or additive was put into her food which made her feel ill. She expressly stated that she did not think she was "poisoned." Rather, she testified that she believed her meal was tampered with as a means of harassment. Moreover, claimant was ill enough that she was treated at the hospital for her ailment.

Although the Referee believed Mr. Mitch when he denied tampering with claimant's food, the Referee did not explain why he did not believe claimant's denial when Mr. Mitch accused her of hitting him, although there is no evidence in the record or corroborating testimony to support Mr. Mitch's assertion. However, claimant's testimony concerning the tampered food is buttressed by her visit to the hospital, her written documentation of the incident to her employer at the time it happened, and co-worker Ms. Johnson's testimony.

The Referee found that claimant had accused Mr. Mitch of failing to provide medications to Mrs. Swogert. I do not share the Referee's perception in this regard.

Upon a review of the record, I find that claimant merely testified that Mrs. Swogert's "eyedrops would expire, and he would not let me get a new bottle." (Tr. 79). Claimant's testimony, in context, was describing the lack of control she had over matters in the household. It is Mr. Mitch who alleged that he had been accused of not picking up Mrs. Swogert's prescriptions. Mr. Mitch denies the accusation he himself asserted. However, as there is no evidence on the matter, and claimant did not raise the issue, I would find this matter to be inconsequential as to claimant's credibility.

The Referee found that claimant accused Mr. Mitch of poisoning Mrs. Swogert's dog, Nelly. I do not find that the facts surrounding this incident discounts claimant's credibility.

Claimant testified that the dog was poisoned due to two boxes of D-Con rat poison that had been sitting down in the basement for a whole year. One box was apparently left out and the dog got into it, eating some of the poison. Claimant testified that she had to induce vomiting with the dog and that the next day she reported it to her employer. She testified that she also told Mr. Mitch about it. Claimant indicated that she believed that Mr. Mitch was responsible for leaving the box out which the dog got into.

On the other hand, Mr. Mitch testified that claimant accused him of poisoning the dog. He testified that he had put the rat poison behind the freezer, apparently where the dog could not get to it. However, Mr. Mitch testified that he also found the previous day's paper on the floor with rat poison on it, out in the open. Mr. Mitch testified that he had not put the rat poison out in the open.

Although claimant's and Mr. Mitch's testimony are not completely in sync, the important point, I believe, is that Mr. Mitch's testimony substantiates claimant's testimony, in that, either the dog did get poisoned or it was possible that the dog got poisoned. Whether claimant did or did not accuse Mr. Mitch of the poisoning is not particularly relevant. What is relevant is that the testimony in the record indicates that it is possible for the dog to have been poisoned and someone was responsible for leaving the rat poison out in the open. Whether or not claimant pointed to the correct person does not diminish her credibility. She simply came to an conclusion which its basis (that the dog could have been poisoned) is supported by the record.

The Referee found that claimant and Mr. Dotten called each other derogatory names. The evidence does not support this sweeping conclusion.

Claimant testified that she did not call Mr. Dotten names. SAIF did not put on any evidence to rebut claimant's testimony, other than Mr. Dotten's testimony. For the reasons already stated above, Mr. Dotten's testimony must be regarded with doubts. However, if one is to give weight to his testimony, I note that he freely admitted that he called claimant a "bitch."

The Referee found that a few weeks prior to the February 24, 1990 incident, claimant threatened Mr. Dotten. There is absolutely no evidence in the record that any such event happened. Inasmuch as

Mr. Dotten cannot substantiate this allegation and it was summarily rebutted by claimant, I would have to dismiss this allegation for lack of proof. Accordingly, I cannot give Mr. Dotten's testimony on the matter any weight.

In sum, there is no evidence that claimant was an "aggressor" or an "active participant" during the February 24, 1992 incident. Thus, the "aggressor defense" is only that, a defense raised but not proven. SAIF has provided merely speculation and allegations unsupported by the record. I do not find that that is enough to slay claimant's claim, which I find is established by the record as a whole, once all the unproven speculations, irrelevant matters and smoke screens have been cleared away.

Therefore, based on claimant's version of the events surrounding the February 24, 1990 incident and considering the medical evidence which is consistent with claimant's account, I find that claimant suffered an accidental injury arising out of and in the course and scope of employment. ORS 656.005(7)(a). Moreover, I am persuaded that claimant's work incident was a material contributing cause of her need for medical services and disability. Id; Mark N. Wiedle, 43 Van Natta 855 (1991). Finally, based on her physicians' observations and conclusions, claimant's injury has been established by medical evidence supported by objective findings. Suzanne Robertson, 43 Van Natta 1505 (1991).

Accordingly, I would reverse the Referee, and thus, I must dissent.

In the Matter of the Compensation of
ANNA L. WILSON, Claimant
WCB Case No. 91-12537
ORDER ON REVIEW
Myrick, et al., Claimant Attorneys
David Schieber (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Neidig.

The SAIF Corporation requests review of Referee Brown's order that set aside its denial of claimant's back 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

SAIF argues that the Referee incorrectly analyzed the claim as one for accidental injury rather than occupational disease. Specifically, SAIF alleges that claimant's symptoms, because they were due to a preexisting condition, were not sudden in nature nor were they unexpected in view of the fact that her job required substantial lifting.

We agree with the Referee that the claim should be analyzed as an accidental injury under ORS 656.005(7)(a). Claimant proved that the onset of her symptoms was sudden, occurring over the course of a single work day on May 6, 1991. Moreover, although claimant has a preexisting degenerative disc condition, the record demonstrates that she had no ongoing back symptoms prior to May 6. Thus, this case is distinguishable from Taylor v. Multnomah County School Dist. No. 1, 109 Or App 499 (1991), and Wausau Insurance Company v. Huhnholz, 85 Or App 199 (1987), wherein the court held that the claimants did not suffer compensable injuries because they had been experiencing continuous pain prior to work-related incidents. Thus, we 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); Valtinson v. SAIF, 56 Or App 184 (1982).

In order to establish the compensability of an accidental injury, claimant must prove that work activities were a material contributing cause of her need for medical services and/or disability. See e.g.

Mark N. Wiedle, 43 Van Natta 855 (1991). Here, there is evidence that claimant has a preexisting degenerative disc disease. (Exs. 5, 6-3). Claimant underwent surgery for a disc herniation at C6-7. (Exs. 7, 8).

Claimant's treating surgeon, Dr. Campagna, neurologist, reported that claimant's cervical condition and current need for treatment are the result of a material worsening of her degenerative disk disease, and that the worsening was caused by her job activities as a certified nurse's aide (CNA). (Ex. 19).

Dr. Dinneen, orthopedist, and Dr. Barth, neurologist, conducted an independent medical examination. They found that claimant's need for medical treatment was the result of natural degenerative processes and that a "mild central spinal stenosis made her a bit more susceptible to the problem." (Ex. 20-4). Dr. Dinneen later clarified that the major contributing cause of claimant's condition is the degenerative changes of her cervical spine, rather than her work duties as a CNA. (Ex. 21-1).

Dr. Litwiller, D.C., treated claimant prior to Dr. Campagna. Litwiller concurred with a letter drafted by claimant's attorney that stated that claimant's history of onset of symptoms indicated that her job activities were the major contributing cause of her need for surgery. (Ex. 22). The letter further indicated that based on the radiological studies, there was no evidence that claimant's degenerative condition had worsened. (Id).

Based on the reports of Drs. Campagna, Dinneen and Barth, we find that although the surgery was for a disc herniation, the cause of claimant's symptoms was a worsening of her degenerative condition. We find that these reports are more persuasive than the opinion of Dr. Litwiller, given Dr. Campagna's status as the treating physician and surgeon, as compared to Dr. Litwiller's more limited training. We give particular weight to Dr. Campagna's report; he is the treating physician and we find no reason not to defer to his opinion. We, therefore, find that claimant proved the compensability of her claim for an accidental injury. See Weiland v. SAIF, 64 Or App 810 (1983).

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 is $1,200, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 6, 1992 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
JIMMIE D. WRAY, Claimant
WCB Case No. 90-17326
ORDER ON REVIEW
Bruce Smith, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Moller and Hooton.

Claimant requests review of Referee Mongrain's order that upheld the insurer's denial of his claim for a low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's low back condition was to be analyzed as an occupational disease and, under such an analysis, that it was not compensable. Alternatively, the Referee concluded that claimant's low back condition would be compensable if properly considered to be an industrial injury. On review, claimant contends that his claim is properly analyzed as an accidental injury. We agree with claimant's characterization of the claim.

An injury is distinguished from an occupational disease both by the fact that the former is said to be unexpected, and the fact that where an occupational disease is gradual in onset, an injury is "sudden in onset." James v. SAIF, 290 Or 242, 248 (1981); Clark v. Erdman Meat Packing, 88 Or App 1 (1987); O'Neal v. Sisters of Providence, 22 Or App 9, 16 (1975).

After our de novo review of the record, we conclude that claimant's condition was the result of an injury that occurred in July 1990, rather than an occupational disease. It is undisputed that in the latter part of July 1990, claimant used a crow bar for 30 to 40 minutes to pry open the "belly dump" of a trailer in the course and scope of his employment as a truck driver. Further, claimant testified that as he and a coworker were attempting to pry open the "belly dump" he felt "something" and noticed a "tingling" sensation in his low back. (Tr. 6, 7). Claimant testified that after the "belly dump" was pried open, he felt "a little pain" in his low back. (Tr. 4). Claimant testified that the pain continued over the next three days as he continued to drive a truck which had a tilted seat and then, on the fourth day, his pain became so severe that he was unable to walk and was required to seek medical treatment. Moreover, the record shows that claimant consistently referred to this discrete and identifiable crow bar event and subsequent irritation to his back by the tilted truck seat to Dr. Robertson, his treating physician, Dr. Newell-Eggert, a consulting physician, and Tim Palmesano, his physical therapist. (Exs. 2B; 5; 8; 9).

We note that, although claimant told the dispatcher at work on July 27, 1990 that he did not know what had caused his back problems, we are persuaded, nonetheless, that claimant has established that an injurious event occurred during a discreet period of time in July 1990. Further, we are not dissuaded by claimant's candid testimony that he did not associate the crow bar incident to his back pain until after he sought treatment and endeavored to recall or cipher the triggering event. (Tr. 4-7).

In addition, we conclude that claimant's injury was unexpected. In this regard, prior to the crow bar incident, claimant pulled muscles in his back in 1957 and was off work for three days. (Tr. 16). Claimant testified that he had not missed any work due to his back since that time. (Tr. 16, 17). Further, he testified that his back had not been giving him problems prior to the July 1990 crow bar incident. (Tr. 17). Therefore, we find that it is more likely that his back condition was the result of the crow bar incident and tilted seat than "an inherent hazard from continued exposure" to his general employment as a truck driver. See Donald M. Drake Co. v. Lundmark, 63 Or App 261 (1983).

Accordingly, we analyze claimant's claim as one for a compensable injury under ORS 656.005(7) rather than an occupational disease under ORS 656.802.

Claimant suffers from both a preexisting degenerative facet disease and congenital angulation of the joints at L5-S1. At hearing, the insurer raised claimant's preexisting conditions as a defense to his claim. In cases involving preexisting conditions, we have held that whether a claim is compensable is a two-part test. Bahman M. Nazari, 43 Van Natta 2368 (1991). First, claimant must establish that he suffered an accidental injury arising out of and in the course of employment, which was a material contributing cause of his disability or need for medical treatment. See ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). Claimant's disability or need for medical treatment must be established by medical evidence supported by objective findings. See Suzanne Robertson, 43 Van Natta 1505 (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 the need for treatment, claimant must establish that the injury was the major contributing cause of the resultant disability or need for medical treatment. ORS 656.005(7)(a)(B).

On this record, we first conclude that claimant has established compensability of his July 1990 injury. The medical evidence establishes that the July 1990 injury was a material contributing cause of claimant's disability and need for medical services. In particular, the opinions of Drs. Robertson and

Newell-Eggert support our conclusion. Dr. Newell-Eggert opined in this regard that the crow bar incident initiated claimant's facet syndrome. Dr. Robertson opined that claimant's back was "injured by the strain of" the crow bar incident. Accordingly, we find that claimant has established the occurrence of a compensable injury in July 1990.

We next consider whether claimant's compensable injury has combined with his preexisting back condition to cause or prolong his disability or need for treatment, and whether the injury is the major contributing cause of the resultant disability or need for medical treatment. ORS 656.005(7)(a)(B). We find that the causation of claimant's resulting symptomatic lumbosacral facet syndrome presents a complex medical question, the resolution of which depends 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 note that "magic words" are not required in a case in which the record, as a whole, satisfies claimant's burden of proof. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986).

Dr. Dixon, radiologist, conducted diagnostic studies of claimant's spine. At a deposition, he acknowledged that by just looking at claimant's diagnostic films or at his physical condition it is impossible to determine the etiology of his pain. (Ex. 9A-12). However, Dr. Dixon also testified that it was his opinion that claimant's work exposure, as described in Drs. Robertson and Newell-Eggert's reports, more likely than not caused claimant's disabling pain. (Ex. 9A-10, 14). The insurer argues on review that Dr. Dixon also stated that "claimant's degenerative facet syndrome can become symptomatic from literally any trauma or no trauma at all." (Resp. Br. p 7). However, we are not persuaded by that argument. What is relevant here is that claimant's lumbar facet syndrome was precipitated by the pry bar incident combined with the uneven seat, events which in fact occurred at work. Dr. Dixon does not opine otherwise.

Dr. Robertson is claimant's treating physician and has treated claimant both before and after his July 1990 work injury. Dr. Robertson opined that claimant "has a back predisposed to injury, aggravated by the tilting seat, and finally injured by the strain of the forced 'Belly Dump'." (Ex. 9). We conclude that Dr. Robertson's opinion is not particularly helpful for purposes of determining whether claimant's compensable back injury "is and remains" the major contributing cause of his need for treatment and disability.

Dr. Newell-Eggert acknowledged that the issue of whether or not claimant's work history is the major cause of his condition is difficult to assess. (Ex. 8-2). The doctor opined that claimant's "facet syndrome was initiated/precipitated when opening the belly of his truck." Dr. Newell-Eggert subsequently stated that when she saw claimant on August 16, 1990, his major need for treatment was the facet syndrome. (Ex. 11).

We find that, read together, Dr. Newell-Eggert's opinions establish that the compensable work incident in July 1990 was the major contributing cause of claimant's resultant need for medical treatment. Accordingly, the insurer's denial is set aside.

In reaching this conclusion, we are finding claimant's current resultant disability and medical treatment compensable. This is not a determination that claimant's underlying degenerative and congenital conditions are themselves compensable. Rather, it is a conclusion that claimant's current lumbar facet syndrome is attributable, in major part, to his compensable July 1990 injury.

For prevailing on the issue of compensability, claimant's counsel is entitled to an assessed attorney fee. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services at hearing and on Board 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 record and appellant's briefs on review), the complexity of the issue and the value of the interest concerned.

ORDER

The Referee's order dated June 6, 1991 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing in accordance with law. For services at hearing and on review, claimant counsel is awarded an assessed attorney fee of $3,000, to be paid by the insurer.

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KEY TO CITATIONS IN COURT REPORTS

Citation → Cite as 113 Or App 411 (1992) June 10, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Julie Gasperino, Claimant.
ALBANY GENERAL HOSPITAL and FUTURE HEALTH, INC., Petitioners,
v.
Case name in BOLD → JULIE **GASPERINO**, Respondent.
(WCB 90-10991; CA A70011)

Page breaks in Court Reports

113 Or App 413> Employer seeks review of a Workers' Compensation Board order that affirmed the referee's order setting aside employer's denial. We affirm. Claimant was at work, she slipped and fell backward. She sought treatment from her family physician. Employer accepted the claim. Claimant responds condition is directly related to the slip and fall. The legislature did not change standard for determining compensability **<113 Or App 413/414>** of a condition or need for medical treatment.

Cite as 314 Or 102 (1992) August 20, 1992

IN THE SUPREME COURT OF THE STATE OF OREGON
In the Matter of the Compensation of Charlene Toole, Claimant.

CHARLENE **TOOLE**, by and through the Professional Liability Fund, Respondent on Review,
v.
EBI COMPANIES, Petitioner on Review.
(WCB TP-89003; CA A62038 (Control))

In the Matter of the Compensation of Victor S. Lloyd, Claimant.

VICTOR S. **LLOYD**, by and through the Professional Liability Fund, Respondent on Review,
v.
PORT OF PORTLAND, Petitioner on Review.
(TP-89022; CA A62117)

In the Matter of the Compensation of Roger L. Shephard, Claimant.

ROGER L. **SHEPHARD**, by and through the Professional Liability Fund, Respondent on Review,
v.
EBI COMPANIES, Petitioner on Review.
(TP-89010; CA A62386) (SC S38434) (Cases Consolidated)

In Banc
On review from the Court of Appeals.*
Argued and submitted March 2, 1992.
Ridgway K. Foley, Jr., P.C., of Schwabe, Williamson & Wyatt, Portland, argued the cause for petitioners on review. With him on the petition was M. Elizabeth Duncan.
Deborah L. Sather, of Cooney, Moscato & Crew, P.C., Portland, argued the cause for respondents on review and filed the response to the petition.

PETERSON, J.
The decision of the Court of Appeals is affirmed in part and reversed in part. The orders of the Workers' Compensation Board with respect to claimants Toole and Shephard are affirmed. The order of the Workers' Compensation Board with respect to claimant Lloyd is affirmed in part and vacated in part.

*Judicial review of orders of the Workers' Compensation Board. 108 Or App 57, 815 P2d 216 (1991).

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314 Or 105> The question in these three consolidated workers' compensation cases is whether the statutory lien of an insurer or self-insured employer on the proceeds of an injured worker's recovery against a negligent third party extends to the proceeds of a malpractice action against an attorney based on the attorney's mishandling of the worker's third-party negligence action. We hold that it does.

Because our conclusion turns on statutory provisions concerning the lien and third-party actions, we begin with a discussion of the relevant statutes. ORS 656.154 provides:

> "If the injury to a worker is due to the negligence or wrong of a third person not in the same employ, the injured worker * * * may elect to seek a remedy against such third person."

A worker who is entitled to seek a remedy against a third person under ORS 656.154 shall elect whether

to proceed against the third person for damages. ORS 656.578.[1] Each of the three claimants in the present cases elected to proceed with a third-party action for damages.[2]

ORS 656.580(2) grants a lien to the paying agency:

> 314 Or 106 > "The paying agency has a lien against the cause of action as provided by ORS 656.591 or 656.593, which lien shall be preferred to all claims except the cost of recovering such damages."

The "paying agency" is "the self-insured employer or insurer paying benefits to the worker." ORS 656.576. ORS 656.593 sets forth the procedures applicable to third-party actions brought by injured workers:

> "(1) If the worker * * * elect[s] to recover damages from the * * * third person, notice of such election shall be given by the paying agency by personal service or by registered or certified mail. The paying agency likewise shall be given notice of the name of the court in which such action is brought, and a return showing service of such notice on the paying agency shall be filed with the clerk of the court but shall not be a part of the record except to give notice to the defendant of the lien of the paying agency, as provided in this section. The proceeds of any damages recovered from * * * [a] third person by the worker * * * shall be subject to a lien of the paying agency for its share of the proceeds as set forth in this section and the total proceeds shall be distributed as follows:
>
> "(a) Costs and attorney fees incurred shall be paid, such attorney fees in no event to exceed the advisory schedule of fees established by the board for such actions.
>
> "(b) The worker * * * shall receive at least 33-1/3 percent of the balance of such recovery.
>
> "(c) The paying agency shall be paid and retain the balance of the recovery, but only to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably to be expected future expenditures for compensation and other costs of the worker's claim under this chapter. * * *
>
> "(d) The balance of the recovery shall be paid to the worker * * * forthwith. Any conflict as to the amount of the balance which may be retained by the paying agency shall be resolved by the board.

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[1] ORS 656.578 provides in part:

> "If * * * a worker receives a compensable injury due to the negligence or wrong of a third person (other than those exempt from liability under ORS 656.018), entitling the worker to seek a remedy against such third person, such worker * * * shall elect whether to recover damages from such * * * third person."

ORS 656.583(1) sets forth the election procedure:

> "The paying agency [the self-insured employer or insurer paying benefits to the worker] may require the worker * * * to exercise the right of election provided in ORS 656.578 by serving a written demand by registered or certified mail or by personal service upon such worker * * *."

[2] Had any of the workers elected to proceed but failed to institute an action against the allegedly responsible third party within 90 days from making the election, the worker's cause of action would have been deemed to have been assigned to the paying agency. ORS 656.583(2). Likewise, an election not to proceed against the third party would have operated as an assignment by the worker of the cause of action to the paying agency. ORS 656.591(1). In either situation, the paying agency could bring an action in the name of the injured worker against the allegedly responsible third party. *Ibid.* The distribution of the proceeds of such an action is governed by ORS 656.591(2).

"(2) The amount retained by the worker * * * shall be in addition to the compensation of other benefits to which such worker [is] entitled under this chapter.

"(3) A claimant may settle any third party case with the approval of the paying agency, in which event the paying <314 Or 106/107> agency is authorized to accept such a share of the proceeds as may be just and proper and the worker shall receive the amount to which the worker would be entitled for a recovery under subsections (1) and (2) of this section. Any conflict as to what may be a just and proper distribution shall be resolved by the board."

Settlements made without approval are void. ORS 656.587 provides:

"Any compromise by the worker * * * of any right of action against [a] * * * third party is void unless made with the written approval of the paying agency or, in the event of a dispute between the parties, by order of the board."

In the present cases, claimants Toole, Lloyd, and Shephard each suffered an employment-related injury. Each claimant's third-party action was either partially or wholly unsuccessful, and each claimant thereafter brought a negligence claim against the attorney who had handled the third-party action. The Professional Liability Fund (PLF) undertook the defense of the attorneys who were accused of malpractice. Although the paying agencies had notified the PLF, claimants, and claimants' new attorneys of their contention that they had enforceable liens on the proceeds of the malpractice actions, the PLF and claimants compromised and settled the claims without the participation or approval of the paying agencies or resolution of any conflict by the Workers' Compensation Board (Board).[3]

The paying agencies then petitioned the Board for relief, asserting the validity of their liens and requesting either a share of the proceeds of the malpractice settlements or a declaration that the settlements were void for lack of the paying agencies' written approval. The PLF asserted that the Board lacked jurisdiction over the paying agencies' petitions for relief, because the malpractice settlement proceeds were not subject to statutory liens. The Board concluded that it had jurisdiction over the petitions, that the paying agencies' liens extended to the malpractice settlements, and that the settlements were void for lack of the paying agencies' written approval.

314 Or 108> Claimants' petitions for judicial review were consolidated by order of the Court of Appeals. That court upheld the Board's jurisdiction over the paying agencies' petitions for relief, but concluded on the merits that their liens did not extend to the proceeds of the malpractice settlements. *Toole v. EBI Companies*, 108 Or App 57, 64, 66, 815 P2d 216 (1991). The Court of Appeals held that the allegedly negligent attorneys were not "third parties" for purposes of ORS 656.154 and 656.578, because they could not be held liable for causing compensable injuries -- *i.e.*, employment-related accidental injuries, ORS 656.005(7)(a) -- to claimants. *Id.* at 66.

The paying agencies petitioned for review, seeking reversal of the Court of Appeals' decision and reinstatement of the Board's orders declaring the settlements void. We allowed review and now reverse the decision of the Court of Appeals insofar as it concluded that the liens did not extend to the malpractice settlements.

The first issue that we address is whether the Board had jurisdiction over the paying agencies' petitions for relief. In *SAIF v. Wright*, 312 Or 132, 137-38, 817 P2d 1317 (1991), this court held that the Board had authority to determine whether an insurance carrier was a "paying agency" under ORS 656.593(3), saying:

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[3] As part of the malpractice settlements, the PLF agreed to defend, indemnify, and hold claimants harmless from any claim or action by the paying agencies based on the assertion of a lien on the settlement proceeds.

> "Finally, we note that the Board is the most appropriate tribunal to determine what a 'paying agency' is in the first instance. The legislature designed the workers' compensation law as an integrated body of statutes, with the Board generally charged with matters relating to the adjudication of claims." (Footnote omitted.)

For the same reason, the Board is the appropriate tribunal to determine whether the attorneys against whom the claims were made are "third parties" under the statutory scheme described above.

ORS 656.587 authorizes the Board to approve a compromise of a claimant's third-party action where there is a dispute between the parties. ORS 656.593(3) provides that the Board shall resolve any conflict between a claimant and a paying agency concerning the "just and proper distribution" of settlement proceeds from the claimant's third-party action. A necessary prerequisite to resolving such conflicts is <314 Or 108/109> the authority to determine whether the settlement at issue is one that requires the approval of the paying agency or the Board or is subject to the Board's power to decide the distribution of proceeds.

Under the statutory scheme, the Board is the appropriate tribunal to decide whether the settlements here were or were not settlements of a third-party claim. We therefore agree with the Court of Appeals that the Board had jurisdiction to resolve whether the claims against the attorneys are third-party claims, whether the malpractice settlements were void for lack of approval by the paying agencies or the Board, ORS 656.587, and whether the paying agencies were entitled to a "just and proper" share of the settlement proceeds. ORS 656.593(3).

Having determined that the Board had jurisdiction to decide the issue presented to it, we now turn to whether it decided that issue correctly. The PLF asserts that the statutes creating the lien, ORS 656.580(2) and 656.593(1), are, by their terms, limited to the proceeds of an action against or settlement with a third person who is alleged to be directly responsible for a claimant's compensable injuries. The Court of Appeals agreed, saying that

> "a compensable injury is the foundation of the concept of a lien on third party recoveries. Legal malpractice results in harm distinct from any type of *injury* that conceivably could be compensable under the workers' compensation law. Even if the measure of damages is the recovery that was likely in the original action but for the malpractice, the recovery is compensation for harm caused by attorney negligence, not for a compensable injury." *Toole v. EBI Companies, supra,* 108 Or at 65-66.

We disagree. When each of the claimants was injured, two potential claims came into being. One was a claim for workers' compensation benefits under ORS chapter 656. The second was a third-party claim for damages that, under ORS 656.154 and 656.576 to 656.595, could have been brought either by the claimant (if he or she elected to do so) or by the paying agency in the claimant's name. When the third-party claim was lost or impaired due to the negligence of that claimant's attorney, a new cause of action arose, a claim against the negligent attorney.

314 Or 110> Like many attorney malpractice actions, that claim involved a "case within a case." To recover damages from the attorney, the claimant would have to establish, first, fault by the attorney that caused damage to the claimant-client and, second, damages sustained as a result of that fault. The second element, the damages element, includes the "case within a case," because, to recover damages, the claimant would be required to establish the cause of action that was lost or impaired due to the attorney's neglect. *See Chocktoot v. Smith,* 280 Or 567, 570, 571 P2d 1255 (1977) ("The jury in the malpractice case is called upon, in effect, to decide what the outcome for plaintiff would have been in the earlier case if it had been properly tried, a process that has been described as a 'suit within a suit.'"). In these cases, the claim lost or impaired was the cause of action against the third party.

The expiration of each third-party claim due to the attorney's neglect gave rise to a malpractice claim. Each malpractice claim was derived wholly from the third-party claim. The damages recoverable in each malpractice action would be the damages that the claimant would have recovered in the original third-party action but for his or her attorney's negligence.

The analysis of a Court of Appeals decision, *Shipley v. SAIF*, 79 Or App 149, 718 P2d 757, *rev den* 301 Or 338 (1986), is relevant and persuasive. In *Shipley*, the injured worker pursued a claim against a responsible third party and obtained a judgment for $98,000. 79 Or App at 151. The third party's liability insurer denied coverage. The injured worker then brought an action against the insurer and obtained a judgment against it for $120,000, the amount of its original judgment, plus interest. *Ibid.* The Court of Appeals affirmed an order of the Board upholding the application of the paying agency's lien to the injured worker's recovery from the insurer, stating:

> "Plaintiff elected to seek recovery against the third party, and he successfully obtained an award of damages for the negligently inflicted injury. Only because the third party's insurer denied coverage did plaintiff have to initiate an action to recover the amount of the judgment. That action was ancillary to the action against the insured, because, without the judgment against the insured, no cause of action against the insurer could have existed. Plaintiff's ultimate <314 Or 110/111> recovery of damages arose out of the negligent conduct of the third party, and the proceeds are properly subject to a lien by SAIF." *Id.* at 152.

Although the present case is different from *Shipley*, the differences are not significant. With appropriate substitutions, the Court of Appeals' reasoning in *Shipley* is apropos here:

> "Only because [of his or her attorney's negligence] did [each claimant] have to initiate an action [against the attorney]. That action was ancillary to the action against the [third party], because, without the [third party's having caused the claimant's compensable injury], no cause of action against the [attorney] could have existed. [Each claimant's] ultimate recovery of damages arose out of the negligent conduct of the third party, and the proceeds are properly subject to a lien by [the paying agency for that claimant]." *Ibid.*

Claimants' *ultimate* recoveries here were compensation for the injuries allegedly caused by the third parties against whom they initially brought actions. Unless claimants could establish that they would have recovered damages for the injuries in their third-party actions, their claims for malpractice would have failed.[4] The malpractice actions at issue here are, like the direct action against the insurer in *Shipley*, wholly derivative of the original actions against the primarily responsible third parties.

By its terms, ORS 656.580(2) creates a lien in the "cause of action" against the third person who injured the worker. Granted, the statutes, by their terms, do not appear to extend the lien to the cause of action against the attorney. Nevertheless, it is clear that the legislative policy can be vindicated only if the paying agency has a lien in the third-party recovery.

In *Johnson v. Star Machinery Co.*, 270 Or 694, 704, 530 P2d 53 (1974), this court noted the pre-eminence of legislative intent in construing statutes:

> 314 Or 112> "Hence, if the literal import of the words is so at variance with the apparent policy of the legislation as a whole as to bring about an unreasonable result, the literal interpretation must give way and the court must look beyond the words of the act."

The court went on to conclude:

> "[A] thing may not be within the letter of the statute and yet be within the intention of its makers. As stated earlier, it is the legislative intent which controls. When such intent is manifest the courts must give it effect, even though to do so does violation to the literal meaning of its words." *Id.* at 706.

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[4] It is irrelevant that the malpractice claims were settled without any admission of liability. Compromise and settlement are part of the litigation process. Whether or not a third party admits liability for a claimant's injury, the paying agency has a right to participate in the settlement and share in the proceeds. ORS 656.587 and 656.593(3). Likewise, the proceeds from these malpractice settlements represent compensation for the injuries suffered by claimants and for which the paying agencies have paid benefits.

This is such a case.

Because the claim against the attorney is derived from the claim against the third party, because the recoverable damages are the damages that the claimant would have recovered from the third party, and because of the clear legislative history, we conclude that an action for attorney malpractice based on the attorney's negligent failure to recover compensation for an injured worker directly from a responsible third party is a third-party action under ORS 656.593 to which a paying agency's lien extends. ORS 656.580(2). Because the malpractice actions were third-party actions and the settlements were not executed with the approval of the paying agency or by order of the Board, ORS 656.587 requires that the settlements be declared void. The Board acted properly in declaring the malpractice settlements void.

The Port of Portland (the paying agency for claimant Lloyd) and the PLF also dispute the amount of the Port of Portland's lien. The Board decided that dispute. The Court of Appeals held that that dispute was beyond the Board's jurisdiction. The Board's correct conclusion that claimant Lloyd's malpractice settlement was void rendered moot any question about the extent of the Port of Portland's lien as applied to that void settlement. The Board, therefore, should not have determined what might be a just and proper distribution of a void settlement, and that part of its order is vacated.

The decision of the Court of Appeals is affirmed in part and reversed in part. The orders of the Workers' Compensation Board with respect to claimants Toole and <314 Or 112/113> Shephard are affirmed. The order of the Workers' Compensation Board with respect to claimant Lloyd is affirmed in part and vacated in part.

Cite as 111 Or App 48 (1992) January 22, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON

RHONDA **BARKLEY**, Appellant,
v.
CORRECTIONS DIVISION, a division of the State of Oregon, KENT WARD and JOHN DOE,
Respondents.
(87-0346C; CA A64332)

Appeal from Circuit Court, Washington County.
Alan C. Bonebrake, Judge.
Argued and submitted September 23, 1991.
Jess M. Glaeser, Portland, argued the cause for appellant. With him on the briefs was Hoffman, Matasar & Glaeser, Portland.
Jas. Adams, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
ROSSMAN, J.
Affirmed.

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111 Or App 50> Plaintiff appeals from a summary judgment in this negligence action. The issue is whether the sexual assault of plaintiff, a convenience store cashier, resulted in an injury for which she would have been entitled to benefits under the workers' compensation laws and for which defendants are therefore immune under the Oregon Tort Claims Act. ORS 30.265(3)(a).

In 1981, Hair began serving time in the Oregon State Correctional Institution (OSCI) for first degree sodomy and first degree sexual abuse. Those convictions arose out of an incident in which he assaulted a convenience store clerk. In 1984, he was transferred to the Corrections Division Release Center (CDRC) and placed on temporary leave. In January, 1985, he was granted "terminal leave" until his July parole date.

In April, 1985, while still in the constructive custody of the Corrections Division and under the supervision of the Field Services Office in Portland, Hair entered a convenience store where plaintiff was employed as a cashier. He unzipped his jeans, exposed his genitals and tried to force plaintiff toward him. She successfully resisted the assault, and Hair fled the store. He was subsequently convicted of first degree attempted sodomy in connection with that incident.

Plaintiff sued defendants[1] for negligence, alleging that: (1) they had failed to comply with the applicable rules and regulations regarding the transfer of inmates from OSCI to CDRC and, even if the rules were followed, they were negligent in the application of those rules; (2) they had failed to comply with mandatory rules and regulations regarding temporary and terminal leave and, even if the rules were complied with, they were negligent in granting temporary or terminal leave to Hair when they knew or should have known that he presented a substantial risk to the community; and (3) defendants had failed to supervise Hair adequately while <111 Or App 50/51> he was on terminal leave. Plaintiff seeks $250,000 in general damages for severe emotional distress.

The trial court concluded that defendants are immune from liability under the Oregon Tort Claims Act, because each of the alleged negligent acts involved the performance of discretionary duties,

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[1] Plaintiff alleges that defendant Corrections Division was responsible for Hair's "parole, probation and temporary leave," defendant Ward was a Corrections Division employee "in charge of and responsible for" his temporary leave program, and defendant Doe, another Corrections Division employee, was the probation officer responsible for his supervision.

ORS 30.265(3)(c),[2] and, also, because plaintiff was covered by Oregon's Workers' Compensation Law at the time of the assault. ORS 30.265(3)(a).

Plaintiff's first assignment of error is directed at the trial court's ruling on workers' compensation coverage. ORS 30.265(3)(a) provides:

> "(3) Every public body and its officers, employees and agents acting within the scope of their employment or duties * * * are immune from liability for:
>
> "(a) Any claim for injury to or death of any person covered by any workers' compensation law."

Plaintiff argues that, although she had workers' compensation coverage at her place of employment, she was not "covered by" workers' compensation for purposes of ORS 30.265(3)(a), because she did not sustain a compensable injury. ORS 656.005(7)(a). She did not file a workers' compensation claim and has received no benefits. The state argues that, because plaintiff's employer carried workers' compensation insurance, plaintiff was covered by the Workers' Compensation Law, regardless of whether she sought or received benefits.

Plaintiff is covered by workers' compensation law, for purposes of ORS 30.265(3)(a), if she suffered a compensable injury. *See Hendrickson v. Lewis*, 94 Or App 5, 7, 764 P2d 577 (1988); *Thornton v. Hamlin*, 41 Or App 363, 365, 597 P2d 1307, *rev den* 288 Or 1 (1979). ORS 656.005(7)(a) then provided, in pertinent part:

> "A 'compensable injury' is an accidental injury * * * *arising* <111 Or App 51/52> *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." (Emphasis supplied.)

Plaintiff concedes that her injury was "accidental," from the employer's perspective, and that it arose in the course of her employment; she acknowledges that Hair attacked her at her place of employment, during work hours, and while she was engaged in work activities. However, plaintiff argues that the assault did not "arise out of" her employment as a convenience store cashier, because it was not work-related. She points to the fact that Hair entered the store to sexually assault her, not to commit a robbery.

Unlike the assault in *Robinson v. Felts*, 23 Or App 126, 541 P2d 506 (1975),3 the attack on plaintiff was not the result of a personal relationship between herself and Hair. Therefore, his motivation alone is not determinative of the compensability of her injury. *See* 1 Larson, *Workmen's Compensation Law* 3-196, 11.11(b) (1990 and 1991 supp). An assault by a third person is deemed to arise out of a claimant's employment when the assault is the result of the nature of the work or when it originates from some risk to which the work environment exposes the employee. *See, generally*, 1 Larson, *supra*, at 3-178, 11.00; 99 CJS, "Workmen's Compensation," 227.

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[2] ORS 30.265(3)(c) provides:

> "(3) Every public body and its officers, employees and agents acting within the scope of their employment or duties * * * are immune from liability for:
>
> "* * * * *
>
> "(c) Any claim based upon the performance of or the failure to exercise or perform a discretionary function or duty, whether or not the discretion is abused."

[3] In *Robinson*, the employee's murder was the result of a troubled personal relationship with the assailant, and it was only by chance that the murder occurred while she was at her place of employment.

[4] Courts in other jurisdictions have reached the same conclusion in similar cases. *See, e.g., Jesse v. Savings Products*, 772 SW2d 425, 427 (Tenn 1989); *Holthaus v. Industrial Comm'n*, 127 Ill App 3d 732, 469 NE 2d 237 (1984).

The Supreme Court has held that a claimant's injury is sufficiently work-related to be compensable under the workers' compensation law if the accident "had its origin in a risk connected with the employment." *Phil A. Livesley Co. v. Russ*, 296 Or 25, 32, 672 P2d 337 (1983).[4] It is undisputed that plaintiff was assaulted while carrying out the business of her employer. She was working alone. The assault occurred late at night, when no other customers were in the store. Plaintiff's position as cashier subjected her to unavoidable and indiscriminate contact with the general public. Behavior <111 Or App 52/53> of store customers was a hazard of her employment. Her work environment increased her exposure to people who might commit violent crimes, and especially to those who have a history of attacking convenience store clerks. There was a sufficient relationship between the assault and a risk connected with plaintiff's employment to conclude that the injury arose out of and in the course of her employment.

We turn to plaintiff's final contention. She argues that her injury was not compensable, because it did not "requir[e] medical services or result[] in disability * * *." ORS 656.005(7)(a). The record shows otherwise. After the assault, she visited her gynecologist and received treatment for problems that she was having in her sexual relationships as a result of the assault. Although she did not seek the assistance of a mental health professional at that time, her present claim is for severe emotional distress.[5] Plaintiff's failure to avail herself of additional medical services for her stress-related symptoms does not mean that she did not sustain an injury that required treatment. *See Finch v. Stayton Canning Co.*, 93 Or App 168, 173, 761 P2d 544 (1988). The fact that one has sought medical services does not establish that one has a compensable injury, *Brown v. SAIF*, 79 Or App 205, 207-08, 717 P2d 1289, *rev den* 301 Or 666 (1986); likewise, choosing *not* to seek medical services does not establish that one has *not* sustained a compensable injury.

Because plaintiff's injury arose out of and in the course of her employment and necessitated treatment, it was compensable under the Workers' Compensation Law. Accordingly, defendants are immune from tort liability. ORS 30.265(3)(a); *Hickey v. Union Pacific Railroad Co.*, 104 Or App 724, 728, 803 P2d 275 (1990).

We need not address the trial court's other rulings.

Affirmed.

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[5] Plaintiff testified that, as a result of the assault, she changed jobs, ended her marriage, "lost interest in everything" and could not control how she acted in crowds.

Cite as 113 Or App 405 (1992) June 10, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Rual E. Tigner, Claimant.

MULTNOMAH COUNTY SCHOOL DISTRICT and LIBERTY NORTHWEST INSURANCE CORPORATION, Petitioners - Cross-Respondents,
v.
RUAL E. **TIGNER**, Respondent - Cross-Respondent,
and EBI COMPANIES, Respondent - Cross-Petitioner.
(WCB 88-00682, 87-14472; CA A67766)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 19, 1992.

Craig A. Staples, Portland, argued the cause for petitioners - cross-respondents. With him on the brief was Roberts, Reinsich, MacKenzie, Healey & Wilon, P.C., Portland.

Ralph E. Wiser, III, Portland, argued the cause for respondent - cross-responsdent. With him on the brief was Bennett & Durham, Portland.

Mark Bronstein, Portland, argued the cause for respondent - cross-petitioner. With him on the brief was Davis & Bostwick, Portland.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

WARREN, P.J.

On petition, award of attorney fees against Liberty Northwest Insurance Corporation reversed and remanded; otherwise affirmed on petition and on cross-petition.

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113 Or App 407> Liberty Northwest Insurance Corporation (Liberty) seeks review of a Workers' Compensation Board order holding it responsible for claimant's occupational disease and awarding claimant an insurer paid attorney fee. EBI Companies (EBI) cross-petitions for review of the Board's denial of its request for reimbursement of claim costs from Liberty. On the petition, we affirm in part and reverse and remand in part; we affirm on the cross-petition.

Claimant worked full time for the Multnomah County School District (Multnomah) and part-time for Mt. Hood Community College (Mt. Hood). EBI was Multnomah's workers' compensation carrier through June 30, 1987, after which Liberty become its carrier. On July 10, 1987, claimant began tratment by a psychiatrist. On August 18, 1987, claimant filed a stress claim against Multnomah. Both insurers denied responsibility for his condition, and claimant requested a hearing. On September 17, 1987, claimant also filed a mental stress claim against Mt. Hood. Liberty, which was also Mt. Hood's carrier, denied compensability of claimant's condition, and claimant requested a hearing.

Because it believed that claimant's stress condition arose out of claimant's work at Multnomah when EBI was on the risk, Liberty, on Multnomh's behalf, requested designation of a paying agent pursuant to ORS 656.307. However, because Liberty, on Mt. Hood's behalf, had denied compensability, the Department of Insurance and Finance rejected Liberty's request, and the matter was then set for a hearing before the referee.

At the hearing, the parties stipulated that Mt. Hood should be dismissed from the proceedings and that the only issue was responsibility as between Multnomah's insurers. Because he found that conditions that existed while EBI was on the risk were more likely to have been the cause of claimant's disability, the referee held EBI responsible. Because the Board found on review that conditions while Liberty was on the risk actually contributed to claimant's disability, it reversed and held Liberty responsible. Liberty <113 Or App 407/408> contends that, in reaching its conclusion, the Board erroneously applied the last injurious exposure rule. We review for errors of law. ORS 183.482(7), (8).

In *UAC/KPTV Oregon TV, Inc. v. Hacke*, 101 Or App 598, 602 n 2, 792 P2d 1219, *rev den* 310 Or 393 (1990), we reaffirmed that the last injurious exposure rule governs the assignment of responsibility when successive insurers of a single employer contest responsibility. In that context, the rule assigns responsibility to the last insurer on the risk when conditions existed that could have caused the

claimant's condition. *See Runft v. SAIF*, 303 Or 493, 500, 739 P2d 12 (1987). To escape responsibility, that insurer must show that the conditions while a previous insurer was on the risk were the *sole* cause or that it was *impossible* for conditions while it was on the risk to have caused the disease. *FMC Corp. v. Liberty Mutual Ins Co.*, 70 Or App 370, 374, 689 P2d 1046 (1984), *on recon* 73 Or App 223, 698 P2d 551, *rev den* 299 Or 203 (1985). Of course, if conditions existed that actually contributed to a claimant's disease while an insurer was on the risk, that insurer cannot avoid responsibility. Accordingly, because the Board found that conditions while Liberty was on the risk actually contributed to claimant's disease, and that finding is not challenged, the Board did not err in holding Liberty responsible.

Liberty also assigns error to the Board's award of an insurer paid attorney fee pursuant to ORS 656.386(1). A claimant is entitled to an insurer paid attorney fee under ORS 656.386(1) only if the employer denies the claim for compensation.[1] If the employer denies responsibility, but not compensability, it has not denied a claim for compensation. *Mercer Industries v. Rose*, 103 Or App 96, 98, 795 P2d 615 (1991), *rev den* 311 Or 150 (1991). On behalf of Multnomah, <113 Or App 408/409> Liberty and EBI denied responsibility only.[2] Accordingly, claimant was not entitled to an insurer paid attorney fee for the responsibility hearing. *See Hunt v. Garrett Freightliners*, 92 Or App 40, 756 P2D 1275 (1988).

Claimant contends that he is entitled to an insurer paid attorney fee, because his attorney was instrumental in obtaining compensation. ORS 656.386(1) authorizes an award of insurer paid attorney fees "[i]f an attorney is instrumental in obtaining compensation for a claimant *and a hearing by the referee is not held* * * * ." (Emphasis supplied.) The quoted portion of ORS 656.386(1) applies to services provided before a hearing and only authorizes insurer paid attorney fees is a hearing is not held. The referee held a hearing. Accordingly, claimant is not entitled to an award based on that, or any other, provision of law.

Having anticipated the Board's reversal of the referee's responsibility decision, EBI asked the Board to order Liberty to reimburse it for claim costs associated with claimant's mental stress condition. The Board denied that request, because it believed that it lacked jurisdiction to order reimbursement between insurers.

In *Western Employers Ins. v. Foster*, 90 Or App 295, 752 P2d 852 (1988), we held that an insurer that provides benefits to a claimant that another insurer was actually responsible for is entitled to reimbursement of those benefits from the responsible insurer. Although in that case we upheld a Board order directing one insurer to reimburse another, we did not specifically address whether the Board had the authority to issue that directive. We resolved that issue in *EBI Companies v. Kemper Group Insurance*, 92 Or App 319, 322, 758 P2d 406, *rev den* 307 Or 145 (1988), where we held that the Board lacked jurisdiction over a reimbursement dispute, because the dispute is not a matter concerning a claim. Subsequently, we determined that the authority to order reimbursement rests in the Department of Insurance and Finance. *Liberty Northwest Ins. Corp. v. SAIF*, 99 Or App <113 Or App 409/410> 729, 733, 784 P2d 123 (1989). Accordingly, the Board did not err by concluding that it lacked jurisdiction to order reimbursement.

On petition, award of attorney fees against Liberty Northwest Insurance Corporation reversed and remanded; otherwise affirmed on petition and on cross-petition.

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[1] ORS 656.386(1) provides:

"In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee. 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] Claimant contends that he is entitled to insurer paid attorney fees, because Liberty denied compensability on Mt. Hood's behalf. Nevertheless, because Mt. Hood was dismissed from the proceedings, none of the insurers participating in the hearing had denied compensability. A claimant cannot bootstrap entitlement to insurer paid attorney fees on a nonparticipating insurer's denial of compensability.

Cite as 113 Or App 411 (1992) June 10, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Julie Gasperino, Claimant.

ALBANY GENERAL HOSPITAL and FUTURE HEALTH, INC., Petitioners,
v.
JULIE **GASPERINO**, Respondent.
(WCB 90-10991; CA A70011)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 18, 1992.
Adam T. Stamper, Medford, argued the cause for petitioners. With him on the brief was Cowling & Heysell, Medford.
Karen M. Werner, Eugene, argued the cause for respondent. With her on the brief were James C. Egan and Emmons, Kropp, Kryger, Alexander & Egan, P.C., Albany.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
WARREN, P.J.
Affirmed.

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113 Or App 413> Employer seeks review of a Workers' Compensation Board order that affirmed the referee's order setting aside employer's denial of claimant's claim for thoracic outlet syndrome (TOS). We affirm.

In January, 1989, while claimant was at work, she slipped and fell backward with her arms outstretched behind her, landing on her buttocks and low back. She sought treatment from her family physician, who diagnosed right wrist and shoulder strain, sacroiliac strain and cervical strain. Employer accepted the claim.

Over the next few months, claimant developed numbness and tingling down her arms into her hands. By July, 1989, she had lost grip strength and had experienced decreased range of motion in both wrists. She was referred to various doctors, including specialists, who gave various diagnoses for her condition. In 1990, a TOS specialist found evidence of TOS, which he concluded was materially caused by the January, 1989, fall. He performed surgery in June and July, 1990, which relieved claimant's symptoms. She filed a claim for TOS, which employer denied. At the hearing, the referee found that the 1989 fall materially contributed to claimant's condition, and the Board affirmed.

Employer argues that the Board erred by applying the material contributing cause test to determine whether the claim is compensable. It asserts that, under the 1990 amendment to ORS 656.005(7)(a)(A),[1] the TOS is a consequence of the compensable injury and, therefore, she must prove that her compensable injury was the major contributing cause of the TOS. Claimant responds that her condition is not a consequence of the compensable injury, but is part of it, because the condition is directly related to the slip and fall. She argues that the legislature did not change the material contributing cause standard for determining compensability <113 Or App 413/414> of a condition or need for medical treatment that is directly related to the industrial accident.

The Board considered ORS 656.005(7)(a), as amended in 1990:

> "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,

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[1] Employer argues for the first time in this court that the Board erred in failing to consider this case under ORS 656.005(7)(a)(B), relating to the combination of a compensable injury with a preexisting disease. Employer did not raise that issue or rely on that provision before the Board; indeed, it asserted in its reply brief to the Board that "[t]he issue raised is whether the claimant's current problems have compensably arisen as a consequence of her accepted 1989 claim." We will not address the argument that it raises for the first time on review.

> whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to the following limitations:
>
> "(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.
>
> "(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."

It concluded that the term "consequence" of a compensable injury in ORS 656.005(7)(a)(A) is ambiguous, because it could reasonably be read to include all conditions not initially diagnosed after an industrial accident or to include only consequences caused by injuries sustained in an industrial accident, *i.e.*, complications or related problems that arise from conditions previously deemed compensable. After reviewing the legislative history, the Board concluded that the legislature did not "affect the standard of compensability for conditions intrinsically related to the underlying industrial accident; only the proof required for 'consequences' of conditions previously deemed compensable have been changed to the major contributing [cause] standard." Because the medical evidence indicated that claimant's TOS was a condition that arose directly, although belatedly, from the 1989 slip and fall, and there was medical evidence that the slip and fall materially contributed to her condition, it concluded that it is compensable.

We agree. The reference in ORS 656.005(7)(a)(A) to "consequence" of a compensable injury is ambiguous. Our <113 Or App 414/415> review of the legislative history leads us to the same conclusion as the Board's. The major contributing cause standard of ORS 656.005(7)(a)(A) was not intended to supplant the material contributing cause test for every industrial injury claim. Senator Kitzhaber explained the changes in the 1990 bill:

> "The change, *not for the original injury* but for things that you brought into the workplace or injuries that occur subsequent to the compensable injury, the test is now major contributing cause or 51 percent as opposed to material. * * * I think that's the most significant change in the bill." Interim Special Committee on Workers' Compensation, May 7, 1990, Tape 26, Side A at 150. (Emphasis supplied.)

Representative Mannix's explanation was consistent with Kitzhaber's:

> "In terms of the standard for the compensability of an industrial injury, we do not change the law to measure contributing cause. * * * *We keep the standard for compensability of an industrial injury itself as whether [the] work is a material contributing cause of a given condition* * * *." House Special Session, May 7, 1991 (statement of Representative Mannix). (Emphasis supplied.)

The distinction is between a condition or need for treatment that is caused by the *industrial accident*, for which the material contributing cause standard still applies, and a condition or need for treatment that is caused in turn by the *compensable injury*. It is the latter that must meet the major contributing cause test.[2]

The Board found that claimant's TOS was directly caused by the 1989 slip and fall itself, not by the injuries that she had sustained in the fall. It also found that the 1989 fall was a material contributing cause of the condition. There is substantial evidence to support those findings. Accordingly, we affirm the Board's conclusion that the claim is compensable.

Affirmed.

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[2] An example of a condition that is a consequence of a compensable injury might be back strain caused by altered gait resulting from a compensable foot injury.

Cite as 113 Or App 434 (1992) June 10, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of David G. Mitchell, Claimant.

TOWN & COUNTRY CHRYSLER, Petitioner,
v.
DAVID G. **MITCHELL**, Respondent.
(WCB 89-22598; CA A68825)

In Banc*
Judicial Review from Workers' Compensation Board.
Argued and submitted October 14, 1991; resubmitted in banc April 15, 1992.
Margaret H. Leek Leiberan, Portland, argued the cause for petitioner. With her on the brief were Schuyler T. Wallace and Leiberan & Gazeley, Portland.
No appearance for respondent.
RIGGS, J.
Affirmed.
Warren, J., dissenting.
*Deits, J., not participating.

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113 Or App 436> Employer seeks review of an order of the Workers' Compensation Board that affirmed and adopted the referee's decision that claimant's injury was work-related and, therefore, compensable. We affirm.

The Board made these findings:

> "Claimant began working for employer as a salesman in April of 1989. The annual company picnic was held at Blue Lake Park on September 10, 1989. The picnic is a joint venture with another automobile dealership, and includes a softball game between the two dealerships. The park, food, non-alcoholic beverages, and activities at the picnic were provided by the employer. It is unknown who provided the softball equipment. The primary motivation of employer in sponsoring the picnic is to enable employees and their families to better get to know one another.
>
> "Claimant was scheduled to work the day of the picnic. At a sales meeting prior to the picnic, employees were told that if they were scheduled to work the day of the picnic they were expected to either work or attend the picnic. If such employees did neither, they would be treated individually as if they had missed work, which could, but not necessarily (and probably would not), include termination. Enough employees volunteered at the sales meeting to work the day of the picnic, and although claimant was not paid for attending the picnic, he opted to do so. Claimant injured his left knee while playing in the softball game."

The Board also found that, because claimant was scheduled to work on the day of the picnic, and did not do so, his attendance at the picnic was required. Therefore, it concluded that the picnic was within the course of claimant's employment.

Workers' compensation benefits are available only for compensable injuries. ORS 656.017. An injury is compensible if it arises out of and is in the course of the claimant's employment. ORS 656.005(7)(a).

Employer argues that the statutory definition of a compensable injury specifically excludes an "[i]njury incurred while engaging in or performing, or as the result of engaging in or performing, any recreational or social activities solely for the worker's personal pleasure." ORS **<113 Or App 436/437>** 656.005(7)(a)(B).[1] When an employer requires a worker's attendance at a recreational or social activity,

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[1] In 1990, the legislature amended ORS 656.005(7)(b)(B) to read "any recreational or social activities *primarily* for the worker's personal pleasure[.]" Or Laws 1990, ch 2, 3. (Emphasis supplied.) That change is not applicable to this case.

activities that are part of the required activity are not performed solely for the worker's personal pleasure. As we discuss below, there is substantial evidence to support the Board's conclusion that claimant's attendance at the picnic was required, and we may not substitute our judgment for that of the Board on any issue of fact. ORS 656.298(6); ORS 183.482(7) and (8).

Employer next argues that the picnic was not within the course and scope of claimant's employment. We have cited with approval Larson's tests for determining whether a social or recreational activity is within the course of employment. *See Colvin v. Industrial Indemnity*, 83 Or App 73, 77, 730 P2d 585 (1986); *Richmond v. SAIF*, 58 Or App 354, 357, 648 P2d 370, *rev den* 293 Or 634 (1982). The tests provide that social or recreational activities are within the course of employment if:

> "(1) They occur on the premises during a lunch or recreation period as a regular incident of the employment; or
>
> "(2) The employer, by expressly or impliedly requiring participation, or by making the activity part of the services of an employee, brings the activity within the orbit of the employment; or
>
> "(3) The employer derives substantial direct benefit from the activity beyond the intangible value of improvement in employee health and morale that is common to all kinds of recreation and social life." 1A Larson, *Law of Workmen's Compensation*, 5-87, 22.00 (1990).[2]

The three tests are stated in the disjunctive and, if an activity satisfies any one of them, it is within the course of employment. *Colvin v. Industrial Indemnity, supra*, 83 Or App at 77.

The Board relied on Larson's second test. It found that claimant was told that he was expected either to work or to attend the picnic. Our review is not *de novo*. ORS 656.298(6); ORS 183.482(7) and (8). We may not substitute <113 Or App 437/438> our judgment for that of the Board on any issue of fact. We note that absolute compulsion is not necessary to satisfy Larson's second test[3] and conclude that there is substantial evidence to support the Board's conclusion that claimant's attendance at the picnic was required.

Employer further argues that, even if attendance at the picnic was required, claimant was not injured as a consequence of attending the picnic, but rather as a consequence of his voluntary participation in the softball game. It argues that there is no evidence that participation was required by employer and that, therefore, claimant's injury could not be work-related. The Board found that "[t]he picnic is a joint venture with another automobile dealership, *and includes a softball game between the two dealerships*. The park, food, non-alcoholic beverages, *and activities* were provided by employer." (Emphasis supplied.) The softball game was part of the picnic. Employer reserved the ballfield for the game. Obviously, it expected that its employees would participate in the picnic activities, including the softball game.

Nevertheless, employer argues that we have consistently held that injuries during employee ball games are not compensable and urges us to make the same holding here. It cites *Richmond v. SAIF*,

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[2] The tests in the 1990 edition are identical to those in the 1979 and 1985 editions, which were cited in our earlier cases.

[3] Larson provides this analysis:

> "When the degree of employer involvement descends from compulsion to mere sponsorship or encouragement, the questions become closer, and it becomes necessary to consult a series of tests bearing on work-connection. The most prolific illustrations of this problem are company picnics and office parties. Among the questions asked are: Did the employer in fact sponsor the event? To what extent was attendance really voluntary? Was there some degree of encouragement to attend in such factors as taking a record of attendance, paying for the time spent, requiring the employee to work if he did not attend, or maintaining a known custom of attending? Did the employer finance the occasion to a substantial extent? Did the employees regard it as an employment benefit to which they were entitled as of right? Did the employer benefit from the event, not merely in a vague way through better morale and good will, but through such tangible advantages as having an opportunity to make speeches and awards?" 1A Larson, *supra*, at 5-120, 22-23.

supra, Rose v. Argonaut Ins. Co.,, 77 Or App 167, 711 P2d 218 (1985); and *Puderbaugh v. Woodland Park Hospital*, 79 Or App 367, 719 P2d 65 (1986). Those cases are inapposite, because they involved employee-organized teams participating in voluntary games that were not part of a required activity and that were only indirectly beneficial to the employer.

113 Or App 439> Affirmed.

WARREN, J., dissenting.

The majority concludes that, when an employer requires a worker's attendance at a recreational or social activity, any activity that the worker engages in while attending the required activity is not performed solely for the worker's personal pleasure. 113 Or App at 438. Because I believe that a worker may engage in one form of recreational activity solely for personal pleasure during the course of a required social function, I dissent. *See* ORS 656.005(7)(a)(B).

Workers' compensation benefits are only available for compensable injuries. ORS 656.017. An injury is compensable if the specific injurious activity is in the course of the worker's employment. ORS 656.005(7)(a). An activity is within the course of employment if it is "reasonably related to [the] employment." *Burge v. SAIF*, 108 Or App 145, 148, 813 P2d 81 (1991).

Generally, work relatedness is determined by evaluating various factors, such as whether the activity was for the benefit of the employer and whether it was directed by or acquiesced in by the employer. *Mellis v. McEwen, Hanna, Grisvold*, 74 Or App 571, 574, 703 P2d 155, *rev den* 300 Or 249 (1985). However, when a worker is engaged in a social or recreational activity, work relatedness is determined by evaluating the worker's motivation for engaging in the activity. A social or recreational activity is not work related if the worker engages in it solely for personal pleasure. ORS 656.005(7)(b)(B) (*since amended by* Or Laws 1990, ch 2, 3).

Regardless of whether the general test, or the specific test for social and recreational activities, applies, work relatedness must always be determined by evaluating the specific injurious activity. For example, in *Brown v. Liberty Northwest Ins. Co.*, 105 Or App 92, 803 P2d 780 (1990), *rev den* 311 Or 261 (1991), we held that the horseplay in which the claimant was engaged at the time of his injury was not work related. We reached that conclusion even though the worker was at his place of employment and was performing his duties for his employer immediately prior and subsequent to the accident. At those times, the worker was performing <113 Or App 439/440> work related activities, but he was not injured by those activities.

Although ORS 656.005(7)(b)(B) establishes a distinct standard for determining whether a social or recreational activity is work related, it does not eliminate the requirement that the specific injurious activity be evaluated under that standard. It is conceivable that a worker would not attend a social activity, such as a company picnic solely for personal pleasure but, while there, would engage in specific activities, such as a softball game or a pie eating contest, solely for personal pleasure. Conversely, a worker may attend a picnic for personal pleasure but, while there, feel compelled by the employer to participate in a discrete activity. ORS 656.005(7)(b)(B) accounts for those possibilities by requiring that the specific injurious activity be one in which the worker did not engage in solely for personal pleasure.

Just as we required an evaluation of the specific, injurious activity in *Brown v. Liberty Northwest Ins. Co., supra*, we must evaluate the specific, injurious activity in which claimant participated to determine if his injury is compensable. Claimant was injured while participating in a recreational activity--a softball game--that was part of a social activity--a picnic--that the Board found was work related. Nevertheless, if claimant played softball solely for personal pleasure, that activity, like the horseplay in *Brown*, would not be work related. Because the Board failed to evaluate whether claimant played softball solely for his personal pleasure, I would reverse and remand this case for reconsideration.

I dissent.

Richardson and Edmonds, JJ, join in this dissent.

Cite as 113 Or App 445 (1992) June 10, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON

DANIEL **DURON**, dba DANIEL DURON COMPANY, Petitioner,
v.
The Filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE** and SAIF CORPORATION, Respondents,
(89-06-23; CA A66673)

Judicial Review from Department of Insurance and Finance.

On respondents' petitions for review. Opinion filed February 26, 1992, 111 Or App 571, 826 P2d 107 (1992).

Peter A. Ozanne, William H. Replogle and Schwabe, Williamson & Wyatt, Portland, for petition of National Council on Compensation Insurance.

Michael O. Whitty, Special Assistant Attorney General, and Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem, for petition of SAIF Corporation.

Ted M. Miller, Portland, *contra.*

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

EDMONDS, J.

Reconsideration allowed on petition of SAIF; opinion modified and adhered to as modified; reversed and remanded for proceedings not inconsistent with this opinion; petition of National Council on Compensation Insurance denied.

Warren, P.J., dissenting.

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113 Or App 447> SAIF petitions for review of our decision, 111 Or App 571, 826 P2d 107 (1992), arguing that we erred in concluding that it was not entitled to bill employer for an additional premium for workers' compensation insurance. We treat the petition as one for reconsideration, ORAP 9.15, modify our opinion and adhere to it as modified.

National Council on Compensation Insurance also petitions for review. We deny its petition without discussion.

SAIF contends that we erred by not remanding to the Department of Insurance and Finance (DIF) to determine the factual issues raised by the application of ORS 737.310(12).[1] ORS 183.482(7). We agree and remand to DIF for that purpose.

SAIF also asserts that our opinion does not "counter" the dissent's argument that our interpretation of ORS 737.310(12) "renders ORS 737.310(10) meaningless." 111 Or App at 578. ORS 737.310(10) permits the director, by rule, to prescribe conditions under which an employer is permitted to divide its payroll among different classifications. The dissent suggests that, on the basis of our interpretation of ORS 737.010(12), "employers could allocate all payroll to the lowest assigned rating classification and then preclude the carrier from challenging that allocation by asserting the reclassification bar of ORS 737.010(12)." 111 Or App at 578. To the contrary, our construction of ORS 737.310(12) does not preclude the carrier from challenging a classification. We give effect to the plain language of the statute by saying that, if SAIF wishes to challenge successfully the classifications of <113 Or App 447/448> employer's employees in 1989 and to charge additional premiums for 1988, it must comply with the statute's requirements. ORS 737.310(12) is a limitation, not a preclusion, on the ability of a carrier to charge retroactive premiums. Furthermore, ORS 737.310(10) no longer has any application to employer's 1988 payroll, because SAIF determined, after the audit, that employer's work

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[1] ORS 737.310(12) (*since amended by* Or Laws 1991, ch 768, 1) provides, in part:

"The insurer shall not bill an insured for reclassifying employees during the policy year unless:

"(a) The insured knew or should have known that the employees were misclassified;

"(b) The insured provided improper or inaccurate information concerning its operations; or

"(c) The insured's operations changed after the date information on the employees is obtained from the insured."

activities should all be placed in one classification and employer does not dispute that action.

Reconsideration allowed on petition of SAIF; opinion modified and adhered to as modified; reversed and remanded for proceedings not inconsistent with this opinion; petition of National Council on Compensation Insurance denied.

WARREN, P.J., dissenting.

I would allow both petitions for the reasons stated in my dissent in *Duron v. National Council on Comp. Ins.*, 111 Or App 571, 826 P2d 107 (1992). Therefore, I dissent again.

Cite as 113 Or App 449 (1992) June 10, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Karen M. Tull, Claimant.

SAIF CORPORATION and COLUMBIA HEALTH CARE, Petitioners,
v.
KAREN M. **TULL**, Respondent.
(WCB 88-17674; CA A68781)

In Banc*
Judicial Review from Workers' Compensation Board.
Argued and submitted November 27, 1991; resubmitted in banc April 15, 1992.
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.
Robert A. Lucas, Rainier, argued the cause and filed the brief for respondent.
EDMONDS, J.
Affirmed.
Warren, J., dissenting.
*Deits, J., not participating

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113 Or App 451> SAIF seeks judicial review of a Workers' Compensation Board order that held claimant's bilateral carpal tunnel syndrome compensable. We affirm.

SAIF makes multiple assignments of error. It first contends that the Board erred in refusing to remand the case to the referee for admission of evidence about when it mailed a 1988 denial letter to claimant. Remand by the Board to a referee for additional evidence is a matter of discretion. *Muffett v. SAIF*, 58 Or App 684, 687, 650 P2d 139 (1982). SAIF argues that its failure to submit the exhibits before or during the hearing was due to claimant's failure to comply with the Board's rule requiring specification of issues. See OAR 438-06-031. However, at the beginning of the hearing, SAIF was aware that compensability was at issue. Moreover, at the hearing, SAIF requested that the record be held open for submission of certain additional exhibits, and the request was granted. Approximately one month after the record was closed, SAIF made another attempt to supplement the record. Because SAIF had already had the opportunity to submit its evidence, the Board did not abuse its discretion when it denied the second request.

SAIF next argues that the Board erred in "concluding that SAIF had the burden of proving that claimant's request for hearing was not timely filed." The Board found that the record did not indicate when claimant was given notice of SAIF's denial. In *Madewell v. Salvation Army*, 49 Or App 713, 716, 620 P2d 953 (1980), we held that, when an employer fails to offer proof of when a letter denying a claimant's claim was mailed, the claimant's request for hearing will be treated as timely. The holding in Madewell controls this issue. The Board did not err.

SAIF next argues that the Board erred when it concluded that there was no evidence in the record as to when SAIF's denial letter was mailed. SAIF offered evidence of a dated letter as evidence

of when SAIF's denial letter was mailed. SAIF relies on OEC 311(n)[1] for the presumption that <113 Or App 451/452> "the ordinary course of business has been followed" and asserts that, "therefore, it must be presumed that the ordinary course of business for a workers' compensation insurer during the period at issue was to mail a denial within 60 days of when it was written." In *Madewell*, we held:

> "While there is a presumption that a writing is truly dated, and that a letter directed and mailed was received in the regular course of the mail, there is no presumption that a letter is mailed on the day it is dated or on the date it was written. * * * Respondent has not put on any evidence to show the filing of the claim was untimely. We thus treat the claim as timely and proceed to the merits." 49 Or App at 716. (Footnotes and citations omitted.)

Again, *Madewell* controls, and the Board did not err.

SAIF also argues that the Board erred in concluding that SAIF's original acceptance of claimant's claim for "somantic [*sic*] dysfunction" included an undiagnosed carpal tunnel syndrome. The Board found that

> "SAIF accepted the claim after receiving an 801 form its claims representative had prepared and submitted on behalf of claimant. That acceptance encompassed the disease causing those symptoms, which turned out to be carpal tunnel syndrome. SAIF may not now avoid responsibility for that condition. *Bauman v. SAIF*, 295 Or 788[, 670 P2d 1027] (1983); *SAIF v. Abbott*, 103 Or App 49[, 796 P2d 378 (1990)]."

SAIF points out that we granted reconsideration in *SAIF v. Abbott*, 107 Or App 53, 810 P2d 878 (1991), and remanded it to the Board. However, we remanded because the Board had not reviewed the proper record. Here, the Board reviewed the proper record and properly applied the rule of *Bauman v. SAIF, supra*, that is, once an employer accepts a claim under ORS 656.262(6),[2] it may not subsequently deny compensability.

113 Or App 453> The dissent would hold that SAIF did not accept claimant's claim, because it did not send a written notice of acceptance to claimant. *See* ORS 656.262(6). The dissent reaches an issue that is not framed by SAIF's assignment of error; Moreover, SAIF does not make the argument on which the dissent relies to hold that there was no acceptance. Also, the dissent's analysis is wrong. It relies on *Johnson v. Spectra Physics*, 303 Or 49, 733 P2d 1367 (1987), *Stevenson v. Blue Cross of Oregon*, 108 Or App 247, 251, 814 P2d 185 (1991), and *EBI Ins. Co. v. CNA Insurance*, 95 Or App 448, 451, 769 P2d 789 (1989), in support of its position.

In *Johnson*, the Supreme Court reaffirmed that *Bauman v. SAIF, supra*, applies only to "specifically" or "officially" accepted claims. 303 Or at 55. The issue was whether the employer's denial

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[1] Neither party suggests that the Oregon Evidence Code is inapplicable to workers' compensation hearings. *See Booth v. Tektronix*, 312 Or 463, 823 P2d 402 (1991).

[2] In 1990, the legislature amended ORS 656.262(6) to provide, in part:

> "Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the employer has notice or knowledge of the claim. *However, if 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. However, if the worker requests a hearing on such denial, the insurer or self-insured employer must prove by clear and convincing evidence that the claim is not compensable or that the paying agent is not responsible for the claim. Notwithstanding any other provision of this chapter, if a denial of a previously accepted claim is set aside by a referee, the board or the court, temporary total disability benefits are payable from the date any such benefits were terminated under the denial.* Pending acceptance or denial of a claim, compensation payable to a claimant does not include the costs of medical benefits or burial expenses. The insurer shall also furnish the employer a copy of the notice of acceptance." (Emphasis supplied.) Or Laws 1990, ch 2, 15.

That change does not apply to this case.

of the claimant's carpal tunnel syndrome was precluded by its earlier acceptance of the claimant's back injury. The court said:

> "ORS 656.262(6) requires that an insurer or self-insured employer furnish the claimant with '(w)ritten notice of acceptance or denial of a claim * * * within 60[3] days after the employer has notice or knowledge of the claim.' An insurer must accept a particular claim in writing, and subsequently deny that particular claim after the 60 days prescribed by ORS 656.262(6) have elapsed, before *Bauman* applies." 303 Or at 56.

The court then concluded that "an insurer's failure to respond to a claim or one aspect of a claim is neither acceptance nor denial." 303 Or at 58. Whether furnishing a notice to a claimant was a necessary element for an "acceptance" to occur under ORS 656.262(6) was not the issue.

113 Or App 454> In *Stevenson*, the Board held that SAIF had not accepted a claim, even though a SAIF employee had placed a check in the "accepted" box on the claimant's 801 form. The form was a claim for tendinitis and a skin rash; SAIF sent a notice to the claimant that it had accepted only the skin rash. The claimant argued that the notation on the form was an acceptance of both conditions. We rejected that argument. We said:

> "The Board found that SAIF had not accepted the tendinitis claim, and *there is substantial evidence to support that finding*. 108 Or App at 252. (Emphasis supplied.)

In *EBI Ins. Co.*, the claimant argued that the employer had accepted his new injury claim when it filed a report with the Workers' Compensation division on a form that said "claim originally denied, now accepted." Two days after filing the report, the employer filed another report explaining that the notation in the earlier report that stated "claim originally denied, now accepted" was a clerical error. On the basis of testimony of a witness, the Board found that the earlier report was not intended to be an acceptance. We affirmed the Board's conclusion that there had been no "back up denial" under *Bauman v. SAIF, supra*, because there had been no previous acceptance by employer. *Stevenson* and *EBI Ins. Co.* stand for the proposition that whether an acceptance occurs is an issue of fact. They do not interpret ORS 656.262(6) to require notice, written or otherwise, as a legal prerequisite for acceptance.

Moreover, the dissent ignores the policy of construing the Workers' Compensation Law in claimants' favor. *See Stovall v. Sally Salmon Seafood*, 306 Or 25, 757 P2d 410 (1988). ORS 656.262(6) does not say that an acceptance occurs only when and if the claimant receives notice of an acceptance. It presumes that acceptance has already occurred when it requires that notice of the acceptance be furnished to the claimant. The dissent's interpretation would produce an incongruous result. Claimant would lose, because SAIF did not do what ORS 656.262(6) told it to do; that is, send a notice of the acceptance to claimant. The legislature could not have intended that interpretation.

SAIF's other assignment of error does not require discussion.

113 Or App 455> Affirmed.

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[3] The statute now requires that written notice be given within 90 days after an employer has notice of a claim.

WARREN, J., dissenting.

The Board found that SAIF accepted claimant's claim for carpal tunnel syndrome (CTS) solely because its claim representative indicated that the claim had been accepted on an 801 form. However, there is no evidence that SAIF ever notified claimant that it was accepting that claim. The majority affirms, on the basis of its conclusion that ORS 656.262(6) "presumes that acceptance has already occurred when it requires that notice of the acceptance be furnished to the claimant." 113 Or App at 454. Because Oregon precedents hold that acceptance cannot occur without notice to the claimant, I dissent.

Claimant contends that SAIF cannot deny compensability or responsibility for her CTS, because it had previously accepted a claim for that condition. In *Bauman v. SAIF*, 295 Or 788, 790, 670 P2d 1027 (1983), the court held that, once an insurer has accepted a claim, it cannot subsequently deny the compensability of that claim. In *Johnson v. Spectra Physics*, 303 Or 49, 733 P2d 1367 (1987), the court clarified that rule, saying:

> "*Bauman* applies only to a claim 'specifically' or 'officially' accepted by the insurer. 295 or at 793-94. 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. (Emphasis supplied.)

Because an insurer must "furnish" the claimant with notice before the rule of *Bauman* applies, we have held that an acceptance cannot occur in the absence of written notice to the claimant. For example, in *EBI Ins. Co. v. CNA Insurance*, 95 Or App 448, 769 P2d 789 (1989), a prior employer argued that a subsequent employer had accepted a claimant's aggravation claim by indicating that the claim had been accepted on a status report to the Workers' Compensation Division. We disagreed, and said:

> "Official notice of acceptance or denial is described by ORS 656.262(6) and must include certain information and advice to the claimant. We conclude that the information on the <113 Or App 455/456> Form 1502 was not an official notice of acceptance." 95 Or App at 451.

Similarly, in *Stevenson v. Blue Cross of Oregon*, 108 Or App 247, 814 P2d 185 (1991), the claimant filed an 801 form with SAIF that listed her disease as tendinitis. SAIF indicated on that form that it was accepting her claim for that condition; however, the notice that it sent to the claimant specified that it was only accepting a claim for "cellulitis/eczema; contact dermatitis." 108 Or App at 248. Subsequently, the claimant filed an aggravation claim, seeking compensation for disabilities resulting from her tendinitis. SAIF denied that claim.

The claimant argued that SAIF improperly denied her aggravation claim, because it had previously accepted her tendinitis condition by marking that it was accepted on the 801 form. We rejected that argument, saying that the "[c]laimant had to show that SAIF specifically accepted her tendinitis claim and officially notified her of that acceptance." 108 Or App at 251. We then concluded that the claimant did not satisfy that burden merely by showing that SAIF indicated that the claim was accepted on the 801 form.

> "[A]n insurer's silence regarding one aspect of a claim is neither acceptance nor denial of that aspect of the claim." *Johnson v. Spectra Physics, supra*, 303 Or at 55. From claimant's perspective, a check mark on the 801 form that she never saw was silence just the same as if SAIF never marked the form at all. Moreover, to say that silence means anything would inject the instability into the workers' compensation system that the court sought to eliminate in *Bauman*. Claimants or insurers would be at liberty to raise the issue of compensability months and years after an injury occurs or disease becomes disabling, merely by asserting there was or was not a response to a claim.

Nevertheless, the majority holds that SAIF accepted claimant's CTS claim by indicating its acceptance on an 801 form. It bases that holding on its conclusion that ORS 656.262(6) presumes that acceptance has occurred before the insurer furnishes a notice of acceptance. It does not explain why essentially the same act did not constitute an acceptance in *Stevenson v. Blue Cross of Oregon, supra*, or *EBI Ins. Co. v.* <113 Or App 456/457> *CNA Insurance, supra*. Neither does it explain why we should ignore the admonition that the rule of *Bauman* does not apply unless the insurer furnishes the claimant with written notice of acceptance or denial of the claim. *Johnson v. Spectra Physics, supra*, 303 Or at 55. Because the majority offers no reason, other than its abject distaste for the result, for us to depart from the controlling precedents on this issue, I dissent.

Joseph, C.J., joins in this dissent.

Cite as 113 Or App 475 (1992) June 24, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Shawn M. Hukari, Claimant.

SAIF CORPORATION and OREGON DEPARTMENT OF TRANSPORTATION, Petitioners,
v.
SHAWN M. **HUKARI**, Respondent.
(WCB 89-08125; CA A67939)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 25, 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.
Willard E. Fox, Salem, argued the cause for respondent. With him on the brief was Allen, Stortz, Fox, Susee & Olson, Salem.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
WARREN, P.J.
Reversed.

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113 Or App 477> Employer seeks review of an order of the Workers' Compensation Board holding that claimant's condition is compensable. We reverse.

Claimant was diagnosed as having Crohn's Disease, an intestinal illness, in 1981. The disease was not caused by her employment. For three years before the events leading to this claim, she had not experienced symptoms of the disease and was not taking any medication for it. In October, 1988, employer initiated an investigation into alleged misconduct by claimant. The investigation lasted ten weeks, during which time claimant was extremely upset, because she believed that the allegations of misconduct were unfounded and unwarranted. She was again extremely upset when she was reprimanded in writing in January, 1989. As a result of the stress of the investigation and reprimand, the Crohn's Disease symptoms drastically increased,[1] which caused disability and for which she sought medical treatment and filed a workers' compensation claim.

The referee concluded that, although the parties had "devoted considerable effort to addressing this case as a mental disorder" under ORS 656.802(1)(b), the claim is for a physical condition, Crohn's Disease, not for a mental disorder. He concluded that the claim is compensable as an occupational disease under ORS 656.802(1)(c), because the investigation and its surrounding circumstances constituted a series of traumatic events or occurrences arising out of her employment. The Board affirmed as to compensability but disagreed with the referee's analysis. It adopted the referee's findings that, although Crohn's Disease is not caused by stress, stress can cause an exacerbation of that condition and that employer's investigation and resulting reprimand constituted "a reasonable corrective evaluation action." The Board concluded that the flare-up of the disease's symptoms was a compensable injury rather than an occupational disease:

> 113 Or App 478> "Under these circumstances, we conclude that the 'flare-up' of claimant's Crohn's disease, * * * took place within a discrete period of work activity, was 'sudden in onset' and should be categorized as an injury."

Accordingly, it did not consider whether the claim was compensable as an occupational disease under ORS 656.802(1), and it did not apply the mental disorder provisions of ORS 656.802(2).[2]

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[1] Claimant experienced extreme abdominal pain and bloating, had inordinately frequent bowel movements and quickly lost 10 pounds.

[2] The 1987 version of ORS 656.802 is the relevant one. Or Laws 1987, ch 713, 4. We cite and apply that version here. The statute was amended again and its subsections renumbered in 1990. Or Laws 1990, ch 2, 43.

By 1987 amendments to the workers' compensation law, the legislature categorized mental disorders as occupational diseases. ORS 656.802(1)(b) provides that an "occupational disease" includes "[a]ny 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." Claims for mental disorders are subject to the requirements of ORS 656.802(2), which provides:

> "Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter:
>
> "(a) Unless the employment conditions producing the mental disorder exist in a real and objective sense.
>
> "(b) *Unless the employment conditions producing the mental disorder are conditions other than* conditions generally inherent in every working situation or *reasonable disciplinary, corrective or job performance evaluation actions by the employer,* or cessation of employment.
>
> "(c) Unless there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.
>
> "(d) Unless there is clear and convincing evidence that the mental disorder arose out of and in the course of employment." (Emphasis supplied.)

The dispositive issue is whether a pre-existing physical disease that is exacerbated by stress at work, resulting in disability or a need for medical treatment, must be treated as an occupational disease under ORS 656.802. If it must, claimant's claim is not compensable, because of the Board's <113 Or App 478/479> unchallenged finding that the stress that caused the worsening of her Crohn's Disease was the result of "a reasonable corrective evaluation action" by employer. *See* ORS 656.802(2)(b).

Before the 1987 amendments, claims for on-the-job stress-caused disability or need for medical treatment, whether physical or mental, were compensable either as occupational diseases or industrial injuries, depending on whether the onset of the condition was sudden or gradual and whether the condition could be said to be expected or unexpected. *See, e.g., Morrow v. Pacific University,* 100 Or App 198, 785 P2d 787 (1990); *Adsitt v. Clairmont Water District,* 79 Or App 1, 717 P2d 1231, *rev den* 301 Or 338, 301 Or 666 (1986); *SAIF v. McCabe,* 74 Or App 195, 702 P2d 436 (1985). All claims involving disabilities that were the result of work-caused stress, regardless of whether the manifestations were psychological or physical, were subject to the same compensability analysis. For example, in *McGarrah v. SAIF,* 296 Or 145, 675 P2d 159 (1983), the court considered whether the claimant's *mental disorder,* which was caused by stressful conditions at work, was compensable. It held that "stress-caused claims for benefits arising out of mental and physical disorders are compensable if they flow from the conditions of the worker's employment," provided that certain requirements were met. 296 Or at 163.[3] In *Leary v. Pacific Northwest Bell,* 296 Or 139, 675 P2d 157 (1983), decided the same day as *McGarrah,* the court applied the same analysis to a claim that the claimant's *physical ailments,* which were caused by on-the-job stressful conditions and events, were compensable.

113 Or App 480> We conclude that the 1987 legislature's use of the term "mental disorder" was intended to encompass all claims for mental or physical disorders arising from job stress. By specifically

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[3] In addressing the pre-1987 definition of "occupational disease," the Court said in McGarrah:

> "The legislature must have been aware of the shift in costs from general welfare or general insurance to workers' compensation that would occur if workers' compensation provided coverage for *mental and physical disorders caused by job stress.* We find no legislative words nor any evidence of legislative intent to indicate that the legislature either intended or did not intend to place that burden on the workers' compensation system. "*If the legislature wants employers and compensation carriers to be relieved from the burden of such claims and wishes to change the occupational disease law to exclude mental disorders,* such as exhaustively set forth in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (3rd Ed 1981), *then the legislature can amend the statute to exclude specifically compensation for mental or physical disorders arising from job stress events and conditions.*" 296 Or at 162. (Emphasis supplied; footnote omitted.)

including mental disorders in the definition of occupational disease, the legislature made clear its intent that *any* claim that a condition is *independently compensable* because it was *caused by on-the-job stress*, regardless of the suddenness of onset or the unexpected nature of the condition, and regardless of whether the condition is mental or physical, must be treated as a claim for an occupational disease under ORS 656.802.

This independent claim for compensation for a stress-caused disability is to be distinguished from a claim for treatment of a consequential mental condition that we have held is not subject to ORS 656.802(2). In *Boeing Co. v. Viltrakis*, 112 Or App 396, 829 P2d 738 (1992), the issue was whether the claimant's mental condition, which was caused by stress resulting from having suffered a compensable injury, was subject to the provisions of ORS 656.802(2). We concluded that it was not, because the "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." 112 Or App at 399. If the condition was compensable, it was because it was related to the compensable injury, not because it was independently work connected. 112 Or App at 399.

Viltrakis is premised on the rule that an employer is liable for the consequences of a compensable injury. *See Williams v. Gates, McDonald & Co.*, 300 Or 278, 709 P2d 712 (1985). Claimant in this case, in contrast, is seeking to establish an independent claim for a condition for which the only work connection is on-the-job stress. Because it is an *independent claim* rather than a *consequential claim*, she must establish that it is compensable under the occupational disease provisions of ORS 656.802. Accordingly, it is not compensable, because the work conditions that caused her stress were "reasonable corrective evaluation action[s] by the employer." *See* ORS 656.802(2)(b).

Claimant argues in the alternative that the claim is compensable under ORS 656.802(1)(c). It is not. *Sibley v. City* <113 Or App 480/481> *of Phoenix*, 107 Or App 606, 813 P2d 69, *rev den* 312 Or 527 (1991).

Reversed.

Cite as 113 Or App 482 (1992) June 24, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Petition of

BROADWAY DELUXE CAB COMPANY, aka BROADWAY ENTERPRISES, INC., dba Broadway Cab Cooperative and dba Broadway Cooperative, Inc., Petitioner,

v.

The filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE**, Respondent below, and SAIF CORPORATION, Respondent.

(89-09-26; CA A68146)

Judicial Review from Department of Insurance and Finance.

Argued and submitted January 31, 1992.

William F. Hoelscher, Portland, argued the cause for petitioner. With him on the brief was Hoelscher & Associates, Portland.

David L. Runner, Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

WARREN, P.J.

Reversed and remanded.

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113 Or App 484> Broadway Deluxe Cab Company (Broadway) petitions for review of a Department of Insurance and Finance (DIF) order directing it to pay SAIF, its workers' compensation carrier, premiums for its "shift lease" taxi drivers. We reverse and remand.

There are no material factual disputes. Broadway owns taxi permits issued by the City of Portland. Each permit allows Broadway to operate one taxi, 24 hours a day. Because Broadway owns no taxis, it sells the right to use its taxi permits to taxi owners,[1] who pay a fixed weekly fee to Broadway for its administrative and dispatching services. The owner-operators are liable for that fee, even if their fares are insufficient to cover it, but Broadway is not entitled to any specific portion of an operator's fares. The weekly fees are Broadway's only source of revenue.

Because payment of the weekly fee authorizes an owner to operate a taxi 24 hours a day, 7 days a week, it is calculated on the assumption that each taxi will be so used. Accordingly, owners who want to maximize their investment arrange to lease their taxis to other drivers to operate when they cannot. Those "shift lease" drivers are also entitled to keep their fares but are responsible for a *pro rata* portion of the owners' weekly fees.[2]

113 Or App 485> All drivers of taxis, whether owners or shift lease operators, who operate under one of Broadway's licenses can use the taxi during a 12-hour shift for any lawful purpose, or not use it at all. Drivers are not required to accept fares and can charge any amount, up to the legal maximum set by the city. They are not required to use Broadway's dispatching service and are subject to few restrictions if they do.[3] They are not assigned to any particular zone and can accept fares in any part of the city. Broadway cannot terminate a shift lease driver's contract in the course of a 12-hour shift.

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[1] Broadway issues two shares of stock for each permit and sells those shares to the owner or owners of a single taxi.

[2] DIF made these findings about the relationship between Broadway, the taxi owners and the shift lease drivers:

"A driver's normal shift is 12 hours a day. An owner-operator may choose to operate their cab each day for a 12-hour shift, and to lease their cab each day for a 12-hour shift.

"* * * * *

"If the owner-operator chooses to lease their cab, [Broadway's] vehicle superintendent maintains a list of drivers who have met [Broadway's] shift lease driver qualifications. The superintendent assigns a shift lease driver to an available cab and the shift lease driver may be assigned a different cab each shift they drive.

"Before [Broadway] allows the potential shift lease driver to lease a cab, the driver must meet [Broadway's] driver qualifications:

"1.attend [Broadway's] driver training program;

"2.have a Class 4 Oregon driver's license;

"3.have a driver's permit issued by the City;

"4.have a business license issued by the City;

"5.be at least 25 years old;

"6.have three years driving experience;

"7.have less than three safety convictions in three years;

"8.have two years verifiable employment;

"9.sign an Independent Contractor Lease-Purchase Contract (Lease Purchase Contract).

"As part of the Lease Purchase Contract, a potential shift lease driver must execute a $250 promissory note. As assured by the Lease Purchase Contract and this promissory note, the shift lease driver agrees to return any assigned lease cab in good working condition less normal wear and tear. The owner-operator must deliver a lease cab to the shift lease driver with a full fuel tank at the beginning of the shift. The shift lease driver must return the cab with a full fuel tank, clean, and in safe operating condition at the end of the shift.

"Major repairs necessitated during the shift lease driver's shift (and arising from an accident or the shift lease driver's negligence) results in the shift lease driver's forfeiture of the $250 promissory note. Repairs exceeding the $250 amount of the promissory note are the owner-operator's responsibility as are major repairs which arise from normal wear and tear or from accidents or negligence occurring off the shift lease driver's shift.

"The Lease Purchase Contract also requires that a shift lease driver, who is scheduled to drive but who cannot do so, notify [Broadway] at least four hours before their shift begins; otherwise the shift lease driver must pay [Broadway] the lease price for the 12-hour shift."

[3] If an operator requests and is assigned a fare, the operator must take that fare, unless another operator agrees to take it.

Although it carried workers' compensation coverage for its administrative staff, Broadway did not provide coverage for owner-operators or for shift lease drivers. In its final premium audit for 1988, SAIF assessed Broadway a premium for shift lease drivers, because it concluded that they are subject workers. ORS 656.027. Broadway contends that, because it did not contract to pay a remuneration to, and did <113 Or App 485/486> not secure the right to direct and control the services of, the shift lease drivers, it is not a subject employer.[4] We agree.

Every employer employing one or more subject workers must provide workers' compensation benefits. ORS 656.023. ORS 656.005(13) defines "employer" as "any person * * * who contracts to pay a remuneration for and secures the right to direct and control the services of any person." Whether an entity is an employer is a question of law. *Castle Homes, Inc. v. Whaite, supra* n 4, 95 Or App at 272; *Michelet v. Morgan*, 11 Or App 79, 83, 501 P2d 984 (1972). The determinative issue is whether Broadway exercised sufficient direction and control over the shift lease drivers to fall within that definition. To resolve that issue, we consider "(1) direct evidence of the right to, or the exercise of, control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to fire." *Castle Homes, Inc. v. Whaite, supra* n 4, 95 Or App at 272.

In *Henn v. SAIF*, 60 Or App 587, 591, 654 P2d 1129 (1982), *rev den* 294 Or 536 (1983), we applied those standards to determine that a magazine salesperson was not under the direction and control of the magazine distributor. We found it significant that the salesperson was not required to work fixed hours or report her daily receipts. Moreover, she could use her own sales techniques, provided that she not violate company policy or the law, and had discretion to choose where and whom she would solicit. The agreement that she signed with the distributor expressly provided that she was not an employee of the distributor. We also found it significant that she was paid on a commission basis, because that kind of remuneration structure "lessens an employer's interest in the details of how the employe spends her time." 60 Or App at 592. We did not consider it decisive that the distributor <113 Or App 186/487> provided training and guaranteed its salespersons a minimum salary if they worked a certain number of hours per month.

DIF concluded that Broadway exercised sufficient direction and control over the shift lease drivers by

> "1. setting the shift lease driver initial requirements;
>
> "2. reserving the right to approve any shift lease driver prior to the owner-operator signing a contract with a driver;
>
> "3. maintaining a list of available shift lease drivers and assigning them to cabs as cabs are available.
>
> "4. requiring a shift lease driver to contact [Broadway] at least four hours in advance if a driver is unable to drive their shift; and
>
> "5. retaining the right to terminate the lease agreement between an owner-operator and a shift lease driver."

Although those findings are relevant, they do not, when viewed in the light of the remaining uncontroverted evidence in the record, support a conclusion that Broadway is the employer of the shift lease drivers.

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[4] Before the Board, and in its petition for judicial review, Broadway argued that the shift-lease drivers are independent contractors. Because a "subject employer" is any entity that employs one or more subject workers, ORS 656.023, we look to see if that entity employs any "workers" to determine if it is a "subject employer." *See Castle Homes, Inc. v. Whaite*, 95 Or App 269, 271, 769 P2d 215 (1989). Independent contractors are not "workers." ORS 656.005(28); *Woody v. Waibel*, 276 Or 189, 195, 554 P2d 492 (1976). By arguing that the shift-lease drivers are independent contractors, Broadway necessarily argued that it is not a "subject employer." We need not decide whether the shift lease drivers are independent contractors.

The uncontroverted evidence is that Broadway exercised no more control over the shift lease drivers than the magazine distributor in *Henn v. SAIF, supra,* exercised over its salesperson.[5] The drivers, like that salesperson, have absolute control over how much or how little they work and can conduct themselves in any manner that they see fit, provided that they do not violate general company policy or the law. The shift lease operators, like the salesperson, control their own rate of compensation by setting fares, choosing zones and deciding how many hours, out of a 12-hour shift, to operate the taxi. In *Henn,* the distributor provided its salespersons with leads, but a salesperson was not required to pursue them. Broadway provides dispatching services, but the shift lease drivers are not required to use them. In *Henn,* <113 Or App 487/488> the distributor furnished magazines to be sold. Broadway, through the owner-operators, furnishes the taxis to the shift lease drivers. Like the salespersons, the shift lease drivers received training from the putative employers.

We cannot discern any substantive difference in the control exercised by the distributor in *Henn* and the control Broadway exercises over its shift lease drivers. Accordingly, DIF erred in concluding that Broadway is the employer of the shift lease drivers and that it is liable for their workers' compensation coverage.

Reversed and remanded.

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[5] In *Castle Homes, Inc. v. Whaite, supra,* 95 Or App at 271, we said that

"where, as here, the facts are generally undisputed, the question of the nature of the employment relationship is one of law."

When reviewing questions of law, if "the evidence relevant to the findings is uncontroverted * * * we may consider the findings that should have been made." *Pruett v. Employment Division,* 86 Or App 516, 520, 740 P2d 196 (1987).

Cite as 113 Or App 531 (1992) June 24, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Robert Hughes, Claimant.

ELECTRIC MUTUAL LIABILITY INSURANCE CO., and PORTLAND AUTO AUCTION, Petitioners,
v.
AUTOMAX, SAIF CORPORATION and ROBERT HUGHES, Respondents.
(WCB 90-00535; CA A69633)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 27, 1991.

Bruce L. Byerly, Portland, argued the cause for petitioners. With him on the brief was Cooney, Moscato & Crew, Portland.

David L. Runner, Assistant Attorney General, Salem, argued the cause for respondents Automax and SAIF Corporation. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Nelson R. Hall and Pozzi, Wilson, Atchison, O'Leary & Conboy, waived appearance for respondent Robert Hughes.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.

Reversed and remanded for reconsideration.

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113 Or App 533> Petitioners[1] seek review of a Workers' Compensation Board (Board) order that assigned full responsibility for claimant's claim to them. We review for errors of law and substantial evidence, ORS 183.482(7), (8), and reverse and remand.

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[1] Petitioners are Portland Auto Auction, its workers' compensation insurer and its claims administrator. Respondents are Automax, its workers' compensation insurer and claimant.

Claimant worked as an auto detailer for petitioner Portland Auto Auction (Portland) and respondent Automax from sometime in 1987 through June, 1989. On November 11 and 12, 1988, while working for Portland, claimant worked 37 1/2 hours buffing cars. The next day, he went to the hospital complaining of severe right shoulder and arm pain and was diagnosed as having acute right shoulder and arm strain. In December, 1988, he filed a workers' compensation claim with Portland. In an unqualified letter of acceptance dated January 25, 1989, Portland accepted the claim.

Claimant continued to work alternatively for Portland and Automax through June 19, 1989, when he quit working altogether because of pain in his right *and left* shoulders and arms. He was referred to a neurologist, who diagnosed bilateral carpal tunnel syndrome (CTS). A week later, the neurologist requested authorization from Portland to perform bilateral carpal tunnel surgery. Portland treated that request as one to reopen the accepted claim. It denied responsibility for claimant's bilateral CTS, denied authorization for the surgery and suggested that claimant file a new injury claim with Automax, which he did. Automax also denied responsibility for the claim. Claimant appealed both denials.

The referee found that claimant's work for both Portland and Automax could have caused his bilateral CTS, applied the last injurious exposure rule and assigned full responsibility to Automax. Automax sought review of that order by the Board. On review, the Board found that Portland had accepted responsibility for claimant's bilateral CTS when it accepted his 1988 claim for right shoulder and arm strain. <113 Or App 533/534> The Board reversed the referee's order and assigned full responsibility to Portland, which seeks review.

The Board's conclusion that Portland accepted claimant's bilateral CTS when it accepted his claim for right shoulder and arm strain is not supported by findings in the record. The Board did not make any finding regarding whether claimant's accepted right shoulder and arm strain was a symptom of, or caused his CTS. That finding is necessary to determine the scope of acceptance. Without it, the Board's conclusion does not rationally follow from its findings. *See Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205, 752 P2d 312 (1988). On remand, the Board should make findings whether Portland's acceptance included CTS and, if it did, whether it included *bilateral* CTS.[2]

Reversed and remanded for reconsideration.

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[2] Because that determination may affect responsibility, we need not now address the arguments regarding the Board's application of the last injurious exposure rule.

Cite as 113 Or App 651 (1992) July 1, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of John T. Seiber, Claimant.

LEBANON PLYWOOD, Petitioner,
v.
JOHN T. **SEIBER**, Respondent.
(WCB 89-14515; CA A68942)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 13, 1991.

Jerald P. Keene, Portland, argued the cause for petitioner. With him on the brief was Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C., Portland.

Brad G. Garber, Salem, argued the cause for respondent. With him on the brief was Michael B. Dye, Salem.

Before Richardson, Presiding Judge, and Joseph, Chief Judge, and Deits, Judge.

RICHARDSON, P.J.

Order requiring employer to pay temporary disability benefits from November 24, 1988, to June 2, 1989, reversed; otherwise affirmed.

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113 Or App 653> Employer seeks review of orders of the Workers' Compensation Board that required it to pay temporary disability payments to claimant to which he was not substantively entitled. We reverse.

Since 1985, claimant had had a compensable carpel tunnel condition that was essentially non-disabling. In April, 1988, employer laid him off because of a work shortage. During the lay off, his carpel tunnel condition became disabling, and employer accepted his aggravation claim. Claimant's treating physician determined that he was unable to work after May 26, 1988, and that he became medically stationary on November 23, 1988. The claim was closed by a determination order on June 2, 1989, with an award of permanent partial disability.

Employer had not paid temporary disability benefits; it concluded that claimant was not entitled to them, because he was laid off from work and was receiving unemployment benefits. The Board held that claimant was entitled to temporary benefits from May 26, 1988, until November 23, 1988. Employer does not contest that holding. However, the Board ruled that, had employer begun paying the benefits when due on May 26, it would have been required to continue payments until the claim was closed by the determination order. It ordered employer to pay temporary benefits for the period from May 26, 1988, through June 2, 1989, the date of the determination order. The Board recognized that there would be an overpayment of amounts actually due and authorized employer to offset the overpayment against any future permanent disability awards.[1]

The Board characterized the payments as "procedural" overpayments. A compensably injured worker is substantively entitled to temporary disability benefits from the onset of disability until the condition is medically stationary. An employer may not unilaterally terminate temporary disability benefits and must continue paying them until the worker is medically stationary and released for return to regular work, or until the worker is medically stationary and <113 Or App 653/654> the claim has been closed by a determination order. *Fazzolari v. United Beer Dist.*, 91 Or App 592, 757 P2d 857, *adhered to* 93 Or App 103, 761 P2d 6, *rev den* 307 Or 236, 765 P2d 810 (1988). When an employer is notified that the injured worker is medically stationary, it will, in most instances, submit the claimant's file to the Department of Insurance and Finance for a determination order, which will designate the medically stationary date and make the appropriate permanent disability award. ORS 656.268(4).[2] Substantively,

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[1] The Board declined to allow employer to offset the overpayment against the permanent partial disability award made by the determination order.

[2] This case was litigated under the law in effect before the effective dates of amendments by the 1990 Special Session of the legislature.

the worker's entitlement to temporary benefits ends on the medically stationary date. Because of delays in processing, the actual payment of temporary benefits continues until the determination order is issued. That delay results in an overpayment of temporary benefits that the employer is entitled to recoup by deduction from any permanent disability compensation awarded. ORS 656.268(10).

Here, claimant was not released to return to work, and his claim was closed by a determination order. He had not received any temporary disability benefits and the processing delay did not result in a procedural overpayment. Payment of temporary disability benefits beyond the medically stationary date is a consequence of the administrative process of claim closure and is not an entitlement. If processing delay does not result in an overpayment, the Board has no authority to impose one.

The Board's rationale for the award was that the lack of a procedural overpayment was due to employer's claim processing decision. It concluded that employer should not reap any advantages from that decision, which it held was incorrect. If an employer unreasonably delays or refuses to pay temporary disability benefits, it is subject to penalties, which is the appropriate way to induce compliance.[3]

Order requiring employer to pay temporary disability benefits from November 24, 1988, to June 2, 1989, reversed; otherwise affirmed.

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[3] The Board declined to impose penalties, because employer's decision not to pay temporary disability benefits was based on a reasonable and legitimate doubt about claimant's entitlement.

Cite as 113 Or App 670 (1992) July 1, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Helen M. Wilson, Claimant.

HELEN M. **WILSON**, Petitioner,
v.
ROSEBURG FOREST PRODUCTS, Respondent.
(WCB 89-24371; CA A69711)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 13, 1991.
Donald Hooten, Eugene, argued the cause for petitioner. On the brief were Dale C. Johnson and Malagon, Moore & Johnson, Eugene.
Richard Wm. Davis, Portland, argued the cause for respondent. On the brief were Stafford J. Hazelett and Davis & Bostwick, Portland.
Before Richardson, Presiding Judge, and Joseph, Chief Judge, and Deits, Judge.
RICHARDSON, P.J.
Affirmed.

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113 Or App 672> In this workers' compensation case, the Workers' Compensation Board upheld employer's denial, because claimant had not filed her claim on time. Claimant seeks review, and we affirm.

Claimant does not dispute the Board's findings. She worked for employer as a skoog operator, which involved light work associated with plugging knot holes in sheets of plywood. In early December, 1988, she relieved another employee on the "round table." Sometime during the shift, she felt a "burning pain" in her neck. When the pain increased, she told her supervisor about the pain and asked to be relieved. She returned then to the lighter duty as a skoog operator.

Claimant continued to work for employer at her regular job until she went on strike with other employees in January, 1989. During the four-month strike, she worked at two other lumber mills, but returned to her regular job with employer after the strike ended in April, 1989. She had periodic pain,

but did not lose any time from work because of it until October, 1989. On October 2, 1989, she first sought medical attention for her neck pain. She filed an injury claim on October 4, 1989. Employer denied the claim on October 27, 1989, on the ground that it was not timely. The Board upheld that denial.

A claimant is required to give notice of an injury within 30 days. ORS 656.265(1). Claimant agrees that she did not file her claim on time under that statute but makes three arguments contesting the Board's ruling.

She first contends that, because employer did not raise the defense of untimely notice within 14 days after her claim, it is waived. She cites *Van Horn v. Jerry Jerzel, Inc.*, 66 Or App 457, 674 P2d 617, *rev den* 297 Or 82 (1984), for that proposition. At issue in that case was a penalty for failure to pay interim compensation. In the course of discussing the reasonableness of the employer's failure to pay interim compensation, we said that, if an employer begins making interim payments under ORS 656.265(4)(b), it waives the right to assert timeliness of notice as a defense. We said, in *dictum*, that, because interim payments must begin within 14 days of <113 Or App 672/673> notice of the injury, ORS 656.262(4)(a), "[i]f the defense is not raised within 14 days, it is waived." 66 Or App at 461.

We did not hold that the defense of timely notice must be raised within 14 days in all instances. The statement in *Van Horn* is an observation of the result when the employer began to make interim compensation payments. Under ORS 656.265(4)(b), failure of a claimant to give notice bars a claim, unless the employer has begun payments. Consequently, if the employer has not begun payments, then that statute does not apply. ORS 656.265(5), however, does apply:

> "The issue of failure to give notice must be raised at the first hearing on a claim for compensation in respect to the injury or death."

Employer raised the issue by its specific denial before the first hearing, and the issue was litigated at that hearing. Employer did not waive the defense.

Claimant next argues that her claim is not barred, because employer had knowledge of the injury. ORS 656.265(4)(a). She contends that, when she told her supervisor that her neck hurt and that she wanted to be put back on her lighter job, that gave employer sufficient knowledge of the "injury" to excuse the late notice.

In *Argonaut Ins. Co. v. Mock* (A41801), 95 Or App 1, 5, 768 P2d 401, *rev den* 308 Or 79 (1989), we construed ORS 656.265(4)(a):

> "It follows that the 'knowledge of the injury' must be sufficient reasonably to meet the purposes of prompt notice of an industrial accident or injury. If an employer is aware that a worker has an injury without having any knowledge of how it occurred in relation to the employment, there is no reason for the employer to investigate or to meet its responsibilities under the Workers' Compensation Act. Actual knowledge by the employer need not include detailed elements of the occurrence necessary to determine coverage under the act. However, knowledge of the injury should include enough facts as to lead a reasonable employer to conclude that workers' compensation liability is a possibility and that further investigation is appropriate."

We agree with the Board's analysis. Claimant only told her supervisor that she was experiencing pain. She did not relate <113 Or App 673/674> the pain to her work or to any particular event. That was not sufficient to put employer on notice that there may have been an injurious event and certainly did not disclose that the pain might be work related.

Claimant's final contention is that her pain was the result of an occupational disease and the time for filing that claim began when she was first made aware of it from her physician on October 2, 1989. She contends that the Board erred as a matter of law in not addressing the merits of her occupational disease claim. She is wrong. The Board addressed the claim and concluded from the evidence that her condition was the result of an injury, not an occupational disease. There is substantial evidence to support the Board's finding.

Affirmed.

Cite as 113 Or App 721 (1992) July 1, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Ellis N. Phillips, Claimant.

ROSEBURG FOREST PRODUCTS, Petitioner,
v.
ELLIS N. **PHILLIPS**, Respondent.
(89-08868; CA A68530)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 4, 1991.
Stafford J. Hazelett, Portland, argued the cause for petitioner. With him on the brief was Davis and Bostwick, Portland.
Michael T. Garone, Portland, argued the cause for respondent. With him on the brief was Jolles, Sokol & Bernstein, P.C., Portland.
Before Richardson, Presiding Judge, and Joseph, Chief Judge, and Deits, Judge.
DEITS, J.
Reversed.

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113 Or App 721> Employer seeks review of an order of the Workers' Compensation Board (Board) requiring it to pay temporary total disability (TTD) to claimant during the time that he was on strike. We reverse.

In 1983, claimant suffered a compensable injury, which employer accepted. The claim was closed in 1986 by a determination order that awarded compensation for temporary and permanent disability. Claimant made an aggravation claim in 1987 that was accepted and closed in the same year. He continued to work full time as an electrician until he went on strike in January, 1989. During the strike, he did not look for or perform other work. He stipulated that, even if work with employer had been available during the strike, he would not have crossed the picket line.

In March, 1989, claimant returned to his doctor, who requested authorization for surgery because of an aggravation of the 1983 injury. Employer authorized the surgery and related medical services but denied claimant's request for TTD benefits during the time that he was participating in the strike, reasoning that claimant had voluntarily withdrawn from the labor market. Claimant had surgery on April 4, 1989. The strike ended on May 15, 1989. Employer began payment of TTD benefits on May 16, 1989. Claimant returned to regular work on June 5, 1989. He sought review of employer's denial of TTD benefits from the date of the surgery to the end of the strike.

The referee denied the claim for TTD benefits during the strike:

> "[C]laimant has failed to meet his burden of proving entitlement to temporary disability benefits for two reasons. First, during the strike, claimant was not a person engaged to furnish services for a remuneration subject to the direction and control of this or any other employer. Thus, he was not a worker. Second, as a consequence of claimant's decision to strike, he was not receiving any wages. Moreover, he was not seeking any work from which he could have earned a wage. Claimant, therefore, did not have any lost wages."

The Board concluded that claimant was still a "worker," because he "had not withdrawn from the work force prior to <113 Or App 723/724> his date of disability." Relying on *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 778 P2d 497 (1989), it reversed the referee on the question of entitlement to TTD benefits during the strike and awarded benefits from April 4, 1989, through May 15, 1989.

Employer argues that the Board erred in concluding that claimant was a "worker" when he was on strike. We agree. In *Dawkins*, the Supreme Court explained the test for determining if a claimant is in the work force:

"A claimant is deemed to be in the work force if:

"a. The claimant is engaged in regular gainful employment; or

"b. The claimant, although not employed at the time, is willing to work and is making reasonable efforts to obtain employment * * *; or

"c. The claimant is willing to work, although not employed at the time and not making reasonable efforts to obtain employment because of a work-related injury, where such efforts would be futile." 308 Or at 258. (Citations omitted.)

It further explained that

"[a] claimant who is not employed, is not willing to be employed, or, although willing to be employed, is not making reasonable efforts to find employment (unless such efforts would be futile because of the work-related injury) has withdrawn from the work force. A claimant who, at the time of the aggravation of the work-related injury, has withdrawn from the work force is not entitled to temporary total disability." 308 Or at 258.

Applying the *Dawkins* test, we conclude that the Board erred in concluding that claimant was a worker in the work force while he was on strike. The record demonstrates, and claimant has acknowledged, that he did not seek other work and that, had he been offered work by employer, he would not have accepted it. We also conclude that claimant was not "engaged in regular gainful employment" while on strike.

To receive TTD for an aggravation of a work-related injury, a claimant must be in the work force at the time of the <113 Or App 724/725> aggravation. As explained in *Cutright v. Weyerhauser*, 299 Or 290, 302, 702 P2d 403 (1985):

"[A] claim for temporary total disability benefits in the absence of wage loss seeks a remedy where there is no damage. Non-workers can sustain medical expenses. They cannot lose earnings."

For the purpose of determining claimant's entitlement to temporary compensation, we conclude that he withdrew from the work force when he decided to participate in the strike. *See Pacific Motor Trucking v. Standley*, 93 Or App 204, 207, 761 P2d 930 (1988).

In *Roseburg Forest Products v. Wilson*, 110 Or App 72, 821 P2d 426 (1991), we considered an analogous question. There, the claimant had sustained a compensable injury. He was unable to work and received TTD benefits. His physician eventually approved his return to modified work. When he arrived at work, he encountered a labor dispute and refused to cross the picket line. The employer then terminated TTD. The issue in *Wilson* was different from the present case, because it concerned whether the employer properly terminated TTD under *former* OAR 436-60-030(5), in contrast to this case, where the issue is whether employer must begin paying TTD. However, the arguments that we considered were similar:

"Claimant argues that he did not impermissibly refuse wage earning employment, because it would have been unreasonable for him to cross the picket line. He also argues that he could not be penalized with a loss of TTD benefits, because his refusal to report for work resulted from his participation in a labor dispute. Employer argues that it is irrelevant why claimant refused to work. It contends that, if approved work was available, claimant had to accept that work, unless his refusal was legally justified." 110 Or App at 75. (Footnote omitted.)

We agreed with the employer's argument, concluding:

"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 P2d 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.

When a claimant refuses physician approved modified work under <113 Or App 725/726> *former* OAR 436-60-030(5), resulting wage loss is not caused by the compensable injury. Therefore, unless the legislature authorized that refusal, wage loss benefits are not available." 110 Or App at 75.

As we noted in *Wilson*, there are instances in which the legislature has expressly declared that workers who participate in labor disputes will not lose specified rights. For example, ORS 656.268(12) provides that, if an attending physician approves a worker's return to work and there is a labor dispute at the worker's place of employment, the worker may refuse to return to work without loss of re-employment rights or vocational assistance. Although there may be sound policy reasons for allowing a worker temporary benefits for disabilities that occur while a worker is on strike, the legislature has not provided for them. We conclude that the Board erred in allowing TTD benefits during the strike period.

Reversed.

Cite as 113 Or App 727 (1992) July 1, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Wilbur A. Lewis, Claimant.

WILBUR A. **LEWIS**, Petitioner,
v.
COOS COUNTY SCHOOL DISTRICT NO. 9., LIBERTY NORTHWEST INSURANCE, WILBUR LEWIS and SAIF CORPORATION, Respondents.
(87-16921, 87-15619, 87-12042; CA A67374)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 27, 1992.
Donald Hooten, Eugene, argued the cause for petitioner. With him on the brief were Christopher D. Moore and Malagon, Moore & Johnson, Eugene.
William McDaniel, Coos Bay, argued the cause for respondent Liberty Northwest Insurance. With him on the brief was Foss, Whitty, Littlefield and McDaniel, Coos Bay.
Thomas E. Ewing, Salem, argued the cause for respondent SAIF Corporation. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Richardson, Presiding Judge, and Deits and Durham, Judges.
DURHAM, J.
Affirmed.

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113 Or App 729> Claimant seeks review of an order of the Workers' Compensation Board that denied his claim for compensation. We affirm.

Claimant has a long history of pain in and nondisabling injuries to his neck, shoulders and back. In 1972, SAIF accepted a neck and back injury.[1] Beginning the same year, x-rays of claimant's dorsal and lumbar spine revealed degenerative changes. The 1972 injury claim was closed in 1973 by a determination order. In 1977, Dr. Campagna diagnosed cervical and lumbar arthritis. Claimant continued to work and to receive intermittent treatment for shoulder and back pain. In the early 1980s, Campagna and two other doctors again diagnosed cervical arthritis and a degenerative shoulder joint.

In 1985, claimant began work as a custodian for the school district. Within a year, he hurt his shoulder. He filed no claim. In April, 1987, he was involved in a car accident. Afterward, he experienced neck and shoulder pain that gradually worsened. Campagna diagnosed that the neck pain was caused by nerve root compression due to arthritis and that the compression was aggravated by the accident. He and Dr. Smith performed separate surgeries on claimant's neck and shoulder.

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[1] Claimant was self-employed and insured by SAIF when he was injured in 1972. Accordingly, he is denoted a respondent.

Claimant sought to reopen the 1972 SAIF claim. He also filed an injury claim against the school district, which Liberty Northwest Insurance (Liberty) insured. SAIF denied that either the neck or shoulder condition were related to the 1972 injury. Liberty did not respond to the claim within 60 days.[2] On October 12, 1987, claimant requested a hearing.[3] On December 30, the Board issued a notice of hearing, which was held on January 27, 1988. At the hearing, Liberty accepted the shoulder condition but denied that the neck <113 Or App 729/730> condition was compensable or that it was responsible for it. Claimant requested a postponement so that he could depose Campagna. The referee denied the request and upheld the denials.

The Board affirmed. It held that claimant had failed to show that he was unable with due diligence to have obtained another report from Campagna before the hearing. It also held that the record was not incomplete, because it contained enough evidence for it to decide that the neck condition was not compensable.

Claimant assigns error to the Board's refusal to remand for further evidence. He asserts that Liberty denied compensability for the first time on the day of the hearing and that he did not know that it would be an issue. The Board found that Liberty had notice of the claim on July 9, 1987. ORS 656.265(1); *see Argonaut Ins. Co. v. Mock*, 95 Or App 1, 5, 768 P2d 401, *rev den* 308 Or 79 (1989). The Board held that, because Liberty did not respond to the claim within 60 days, Liberty had denied it "de facto." *See Barr v. EBI Companies*, 88 Or App 132, 134, 744 P2d 582 (1987).

Claimant asserts that he discovered for the first time at the referee's hearing that Liberty would deny compensability. His request for a hearing, filed over three months earlier, had specified that compensability and responsibility would be at issue. He identified Liberty as the insurance carrier with regard to those issues and others. Moreover, he specified compensability as an issue against SAIF and knew that the claims were consolidated for hearing. Therefore, the issue of "*de facto* denial" is irrelevant.

Claimant also argues that the record was incomplete and that the Board could not determine from it whether the 1972 injury materially contributed to a worsening of his neck condition. *See Manous v. Argonaut Ins.*, 79 Or App 645, 649, 719 P2d 1318 (1986). The Board may remand a case to take further evidence if it determines that the case has been incompletely developed. ORS 656.295(5). The record contains numerous reports from Campagna. In each, he made essentially the same diagnosis: claimant had progressive arthritis in the neck. Campagna's opinion about the etiology of that condition remained unchanged after the accident and <113 Or App 730/731> surgery. Moreover, claimant had had no complaints about neck pain for over 18 months before the automobile accident. The record was adequately developed. *See Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249, 764 P2d 974 (1988).

Claimant also argues that the Board failed to explain how it concluded that no extraordinary circumstances beyond his control existed to justify a remand. *See* OAR 438-06-081. The Board's order sufficiently explained why it refused to remand.[4]

Affirmed.

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[2] The only written response to the claim by Liberty in the record is a form on which it marked a space that indicated that it denied that claimant was entitled to penalties or fees. The form is dated January 11, 1988, 16 days before the hearing.

[3] On November 4, claimant requested a hearing on SAIF's denial. The claims against Liberty and SAIF were consolidated for hearing.

[4] The Board stated that over two months elapsed between claimant's request for a hearing and the hearing. It also recited that claimant's attorney's explanation for failing to depose Campagna was that he unexpectedly had a plethora of cases scheduled for hearing.

Cite as 113 Or App 732 (1992) July 1, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of James E. Peacock, Claimant.

JAMES E. **PEACOCK**, Petitioner,
v.
VENEER SERVICES and SAIF CORPORATION, Respondents.
(88-02788; CA A69400)

Judicial Review from Workers' Compensation Board.
Argued and submitted February 14, 1992.
Donald M. Hooton, Eugene, argued the cause for petitioner. With him on the brief was Malagon, Moore & Johnson, Eugene.
Thomas E. Ewing, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Richardson, Presiding Judge, and Deits and Durham, Judges.
DURHAM, J.
Affirmed.

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113 Or App 734 > Claimant seeks review of a Worker's Compensation Board order denying him vocational assistance benefits. The issue is whether he was properly denied vocational assistance because he cannot come to Oregon to obtain it. We affirm.

Claimant compensably injured his back in 1978. He was awarded 55% permanent partial disability and has had five back surgeries. In 1986, he negotiated a plea bargain on a criminal charge and, pursuant to the plea agreement, received five years' probation, to be spent in Tennessee.

At that time, ORS 656.340(6)[1] provided:

> "Vocational evaluation, help in directly obtaining employment and training shall be available under conditions prescribed by the director. The director may establish other conditions for providing vocational assistance, including those relating to the worker's availability for assistance, participation in previous assistance programs connected with the same claim and the nature and extent of assistance that may be provided. Such conditions shall give preference to direct employment assistance over training."

Pursuant to that statute, the Department of Insurance and Finance (DIF) promulgated OAR 436-120-040(3),[2] which provided that the worker must be

> "available in Oregon for vocational assistance. However, this does not preclude furnishing services at sites outside Oregon if the insurer finds that more effective in the particular circumstances."

In August, 1987, claimant asked SAIF to provide him with vocational services in Tennessee. SAIF denied benefits, because claimant was not available to receive them in Oregon.[3] The director of DIF affirmed SAIF's denial. The Board affirmed the director's order.

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[1] *Former* ORS 656.340(6) was renumbered as ORS 656.340(7) by Or Laws 1987, ch 844, 7. We refer to that version.

[2] OAR 436-120-040(3) has been modified and renumbered as OAR 436-120-040(5).

[3] Tennessee's vocational rehabilitation agency found that claimant was eligible for the vocational services that it administered, but he sought Oregon's greater benefits.

113 Or App 735> Claimant first argues that the Board erred in concluding that his eligibility for vocational assistance should be determined according to the law in effect at the time of the request for services in 1987, rather than on the date of injury in 1978. His reliance on ORS 656.202(2) for that contention is misplaced, because that section "does not apply to vocational assistance benefits." ORS 656.202(5). The Board committed no error.

Claimant argues that OAR 436-120-040(3) exceeds the authority that ORS 656.340(6) grants to the director because it denied assistance to an injured worker who was otherwise entitled to it, in violation of the policy favoring expeditious restoration of injured workers to self-sufficiency "to the greatest extent practicable." ORS 656.012(2)(c).[4]

A worker's right to vocational assistance is not unqualified. ORS 656.340(6) makes those benefits available "under conditions prescribed by the director" and authorized the director to "establish other conditions for providing vocational assistance, including those relating to the worker's availability for assistance * * *." The statute authorized the eligibility rule that claimant challenges. That the rule arguably conflicts to some degree with the legislature's broad policy in ORS 656.012(2)(c) does not alter our conclusion. The specific statutory authority for the rule controls over the general policy statement favoring the self-sufficiency of injured workers. ORS 174.020. The Board correctly upheld the rule. We also reject claimant's argument that the director abused his discretion by declining to waive the eligibility condition or create other conditions that would have resulted in benefits for him. We find no abuse of discretion.

Finally, claimant argues that, if OAR 436-120-040(3) was statutorily authorized, ORS 656.340(6) violates Article I, section 20, of the Oregon Constitution and the right to interstate travel protected by the Fourteenth Amendment to <113 Or App 735/736> the United States Constitution. Oregon Constitution, Article I, section 20, provides:

> "No law shall be passed granting to any citizen or class of citizens privileges, or immunities, which, upon the same terms, shall not equally belong to all citizens."

Claimant argues that ORS 656.340(6) impermissibly divides workers injured in Oregon into two distinct classes: those who can come to Oregon for vocational assistance and those who cannot. However, a privileges and immunities challenge will not succeed if "the law leaves it open to anyone to bring himself or herself within the favored class on equal terms." *State v. Clark*, 291 Or 231, 240, 630 P2d 810, *cert den* 454 US 1084, 102 S Ct 640, 70 L Ed 2d 619 (1981). Here, claimant's probation, not the worker's compensation laws, prevents him from appearing in Oregon to receive vocational assistance, and he makes no challenge to the validity of the probation. The denial of benefits does not offend his right to equal privileges and immunities.

Claimant's challenge under the Fourteenth Amendment also fails. He cites *Memorial Hospital v. Maricopa County*, 415 US 250, 94 S Ct 1076, 39 L Ed 2d 306 (1974), for the proposition that a state violates the right to interstate travel if it denies benefits based on one's residency. *Memorial Hospital* is inapposite, because OAR 436-120-040(3) did not impose a residency requirement. Under the rule, workers need not be residents of Oregon; they must only be available to receive benefits in Oregon. That he must be available in Oregon to receive benefits does not offend his right to interstate travel.

Affirmed.

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[4] ORS 656.012(2)(c) provides:

> "In consequence of these findings, the objectives of the Workers' Compensation Law are declared to be as follows:
>
> "* * * * *
>
> "(c) To restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable * * *."

Cite as 114 Or App 12 (1992) July 8, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of William A. Burt, Claimant.

SAIF CORPORATION, Petitioner,
v.
WILLIAM A. **BURT**, THRIFTEE THRIFTWAY, UNITED EMPLOYERS INSURANCE COMPANY, PERFORMANCE INSULATION/SAIF CORPORATION, ANDERSON FORGE, PRINCETON PROPERTY MANAGEMENT, dba Murray Place Apartments/SAIF CORPORATION and SAFEWAY STORES, INC.,
Respondents,
and JEFF L. ADAMS, dba Adams Landscape Service, Respondent.
(WCB 87-14262; 87-19512; 88-00583; 88-00587; 88-04786; 88-18591; 89-02307; CA A67493)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 16, 1991.

Paul L. Roess, Portland, argued the cause for petitioner. With him on the brief was Acker, Underwood, Norwood & Hiefield, Portland.

David C. Force, Salem, argued the cause for respondent William A. Burt. With him on the brief was Vick & Gutzler, Salem.

Janet M. Schroer and Schwabe, Williamson & Wyatt, Portland, filed the brief for respondents Thriftee Thriftway and United Employers Insurance Company.

Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and John Reuling, Assistant Attorney General, Salem, filed the brief for respondents Performance Insulation and SAIF Corporation.

Thomas M. Christ and Mitchell, Lang & Smith, Portland, filed the brief for respondent Anderson Forge.

Mark P. Bronstein, Portland, argued the cause for respondents Princeton Property Management/SAIF Corporation. With him on the brief was Davis & Bostwick, Portland.

Kenneth L. Kleinsmith and Meyers & Radler, Portland, filed the brief for respondent Safeway Stores, Inc.

Allen W. Lyons, Portland, waived appearance for respondent Jeff L. Adams.

Before Richardson, Presiding Judge, and Joseph, Chief Judge, and Deits, Judge.

RICHARDSON, P.J.

Affirmed.

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114 Or App 15> SAIF, the statutory processing agent for the noncomplying employer, Jeff L. Adams, dba Adams Landscape Service (Adams), seeks review of the Workers' Compensation Board's order holding that Adams is responsible for claimant's low back condition. SAIF agrees that the Board correctly applied the last injurious exposure rule but contends that it improperly rejected a stipulation that Princeton Property Management, dba Murray Place Apartments (Murray Place), was the last employer. We affirm.

Claimant sustained a compensable low back injury in December, 1981, while working for Thriftee Thriftway. The injury was non-disabling, and claimant continued to work at Thriftway until November, 1985. From that date until July, 1987, he worked for several different employers. When his back condition worsened in 1987, he filed an aggravation claim against Thriftway and claims against all other employers.

At a hearing involving all the claims, each employer was represented by counsel. At the commencement of the hearing, the referee asked each counsel to state the period of time that claimant worked for the respective employer. Counsel for SAIF, on behalf of Adams, said that claimant had worked there from April 20, 1987, through July 28, 1987, and counsel for Murray Place said "two days of employment, July 12 and July 29, 1987." The referee then asked if each employer could stipulate to the periods of employment recited. Each counsel, individually, responded yes to the inquiry, except counsel for Murray Place. It is not apparent from the record whether the referee realized that counsel for Murray Place had not responded. However, the referee found that the dates of employment recited "were stipulated to by counsel." There was evidence about the times that claimant worked for each

employer. In particular, claimant testified that, on July 29, 1987, he stopped at Murray Place to pick up a tree that had been cut down and then returned to the job he was working on for Adams. The manager of Murray Place also testified, by deposition, that claimant stopped at the apartment on July 29, 1987, for a few minutes and then left.

114 Or App 16> The referee concluded that Thriftway was responsible for claimant's low back problems. The referee, therefore, did not address the last employment basis for responsibility or the effect of any stipulation. Thriftway appealed to the Board, which concluded that landscaping work independently contributed to claimant's condition. That finding is not challenged on review. After that finding, the responsibility issue turned on a determination of which of two employers for which claimant did landscaping work was the last employer: Adams or Murray Place.

The Board, after noting the stipulation, found that claimant last did landscape work for Adams. SAIF's only argument is that, as a matter of law, the Board cannot disregard the stipulation of the parties about claimant's periods of employment.[1]

Murray Place responds that it did not stipulate and, therefore, is not bound by the stipulation of the other parties. The record is clear that counsel for Murray Place did not respond to the referee's request for stipulation as to the various dates of employment. SAIF acknowledges the state of the record, but it argues that Murray Place should be deemed by its silence to have acceded to the other parties' recitation. We decline to impose an agreement on an ultimate fact from the silence of counsel. Murray Place did not agree that its work was the last potentially injurious employment. The Board's findings are not otherwise challenged.

Affirmed.

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[1] We address only the narrow issue as it is phrased by the parties.

Cite as 114 Or App 22 (1992) July 8, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of David A. Steiner, Claimant.

DAVID A. **STEINER**, Petitioner,
v.
E.J. BARTELLS CO. and SAIF CORPORATION, Respondents.
(TP-91002; CA A69593)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 16, 1991.
Kevin N. Keaney, Portland, argued the cause for petitioner. With him on the brief were Jeffrey S. Mutnick, Robert K. Udziela and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.
David L. Runner, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Richardson, Presiding Judge, and Deits and Durham, Judges.
RICHARDSON, P.J.
Affirmed.

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114 Or App 24> Claimant seeks review of an order of the Workers' Compensation Board that he reimburse SAIF from the proceeds of his settlement of a third-party action. The disputed amount is the portion of his permanent partial disability award that was paid directly to his attorney as attorney fees under ORS 656.386(2). Claimant contends that that amount is not part of compensation subject to reimbursement under ORS 656.593(1)(c). We affirm.

Claimant sustained a compensable injury to both heels and was awarded permanent partial disability by a determination order. On review of the determination order, the referee increased the award and ordered that claimant's attorney receive a fee out of the increased compensation, not to exceed $2,000, under ORS 656.386(2). The attorney fee award was paid directly to the attorney. Consequently, claimant actually received the increased award, less the amount paid to his attorney.

Claimant brought an action against a third party for his injuries and received a judgment. ORS 656.593. SAIF notified claimant of the amount of reimbursement that it was entitled to under ORS 656.593(1)(c), including $2,000 paid to his attorney. Claimant refused to pay the latter amount, and SAIF requested that the Board resolve the issue. ORS 656.593(3). The Board held that attorney fees paid out of compensation pursuant to ORS 656.386(2) retain their identity as compensation and are reimbursable from claimant's third-party action judgment. We agree.

Claimant makes essentially three arguments. First, he argues that the fee was paid directly to claimant's counsel, pursuant to the referee's order, that he never saw that money and, thus, that he received no benefit. He argues that the fee was not compensation that he had received, which is all that SAIF is entitled to be reimbursed. Attorney fees are payable under the workers' compensation law either by the employer, in addition to any compensation, ORS 656.382(1); ORS 656.386(1); ORS 656.390, or by the claimant, from the compensation awarded. ORS 656.386(2). In the latter circumstance, attorney fees for a claimant's counsel remain the **<114 Or App 24/25>** claimant's responsibility. They may be paid out of compensation that claimant receives or from some other source. The fact that the amount allowed is paid by an administrative process directly to the attorney does not change the character of the money as compensation paid to the claimant and not attorney fees paid by SAIF. There was not a separate award of attorney fees to claimant or his counsel. There was an award of permanent partial disability benefits and an authorization by the referee for claimant's attorney to charge a certain amount for his services.

Claimant next argues that attorney fees, however paid, are not part of compensation. He cites *Dotson v. Bohemia, Inc.*, 80 Or App 233, 720 P2d 1345, *rev den* 302 Or 35 (1986), and *Schlecht v. SAIF*, 60 Or App 449, 653 P2d 1284 (1982). Those cases involved attorney fees payable by insurers, *in addition* to compensation. By the very definition of those awards, the fees are not compensation.

Claimant finally argues that, as a matter of policy, allowing SAIF to recover the amount paid to his attorney would unfairly infringe on claimant's incentive to challenge a determination order. The contention is based on claimant's persistent analysis that the fee in this case was paid by SAIF. SAIF paid claimant the compensation ordered, and claimant paid his attorney from that amount. If SAIF is denied reimbursement of all the compensation that it paid, it will have paid attorney fees in addition to compensation, contrary to ORS 656.386(2). Claimant's policy argument is best addressed elsewhere.

Affirmed.

Cite as 114 Or App 26 (1992) July 8, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Darold W. Miller, Claimant.

DAROLD W. **MILLER**, Petitioner,
v.
WAGON TRAIL RANCH and SAIF CORPORATION, Respondents.
(WCB 89-05899; CA A67080)

Judicial Review from Workers' Compensation Board.
Submitted on record and briefs October 30, 1991.
Dan Steelhammer and Brothers, Drew & Steelhammer, Bend, filed the brief for petitioner.
Dave Frohnmayer, Attorney General, Virginia L. Linder, Solicitor General, and Katherine H. Waldo, Assistant Attorney General, Salem, filed the brief for respondents.
Before Richardson, Presiding Judge, and Joseph, Chief Judge, and Deits, Judge.
RICHARDSON, P.J.
Affirmed.

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114 Or App 28> Claimant seeks review of an order of the Workers' Compensation Board that reversed the referee and concluded that claimant had not filed an aggravation claim within the statutory time period. We affirm.

The Board adopted the referee's findings of fact:

"Claimant is a 59 year old maintenance man who was removing a sprinkler head on September 29, 1983, when he heard his back pop and had an immediate onset of excruciating low back pain. The following day he began treating with Dr. Ries, a chiropractor, who diagnosed acute lumbar and cervical sprain with muscle spasms. Dr. Ries began conservative chiropractic treatment and released claimant to modified work with a 30-pound lifting restriction.

"On October 13, 1983, the insurer wrote to the claimant and notified him that his claim was being accepted and that his injury is classed as nondisabling. On October 26, 1983 Dr. Ries wrote to the insurer and reported that claimant was still having recurring pain for which he was continuing chiropractic treatment and that it was undetermined whether claimant would have any permanent impairment. On January 9, 1984, Dr. Ries again wrote to the insurer and advised that he was still treating claimant for continuing low back pain. Dr. Ries again wrote to the insurer on February 29, 1984 and opined that claimant was medically stationary, but he was still subject to flare-ups of his condition and that he would be treated on an as-needed basis.

"Claimant continued to have flare-ups and his condition did not improve, and so Dr. Ries referred him to Dr. Kendrick, a neurosurgeon. On November 20, 1984, Dr. Kendrick diagnosed an L5 root lesion and ordered a CT scan. A mild bilateral disc rupture at L5-S1 was indicated by the CT scan a few days later, and Dr. Kendrick opined that claimant was not medically stationary and prescribed a lumbosacral corset.

"Claimant continued to work for this employer without any time loss, but his low back pain gradually increased. On February 20, 1985, Dr. Ries reported to the insurer that claimant was having increasing difficulty in carrying out his job activities; Dr. Ries opined that claimant will have some degree of permanent disability, but that his conservative chiropractic treatment twice per month was enabling claimant to keep working.

114 Or App 29> "Claimant's low back condition continued to gradually deteriorate and in 1987 his wife began helping him with his work as a maintenance man because he could no longer handle some of the specific jobs. In the spring of 1988, claimant's low

back condition dramatically worsened and he was no longer able to perform his job at all. On May 17, 1988, Dr. Ries reported that claimant had experienced a marked increase in back and leg pain and that he had increased his rate of treatment. On June 20, 1988, Dr. Ries reported to the insurer that claimant was still experiencing severe pain and receiving more frequent treatments.

"On December 13, 1988, Dr. Ries wrote to the insurer and reported that claimant's low back condition had steadily worsened to the point that he was no longer able to work. Dr. Ries recommended that claimant's claim be reopened for time loss effective immediately, or retroactive to May, 1988. Dr. Ries also reminded the insurer that claimant has a ruptured disc in his low back and he will now probably need surgery by Dr. Kendrick.

"On April 3, 1989, Dr. Ries opined that claimant's back condition worsened in May of 1988 and that he has been unable to work since that time. This claim has never been closed and the insurer has never paid claimant any time loss compensation."

The Board made these Findings of Ultimate Fact:

"Claimant did not initially lose time from work, receive temporary disability benefits or sustain permanent disability as a result of his low back injury.

"Claimant did not request reclassification of his injury from nondisabling to disabling within one year of injury.

"Claimant did not file his aggravation claim within five years of injury."

On those findings, the Board concluded that claimant's injury was not misclassified as nondisabling; that, because the claim was not reclassified as disabling within one year after the injury, claimant was required to pursue any aggravation claim that he might have had within five years after the date of injury; and, finally, that none of the various doctor's reports sent to SAIF during that five-year period constituted an aggravation claim.

Claimant's first assignment of error is that the Board applied an incorrect legal standard in reaching its <114 Or App 29/30> conclusion that claimant's injury was not disabling from the outset. The Board applied ORS 656.005(8)(b) and (c),[1] which were the correct legal standards for determining if an injury was disabling at the time of the injury. What claimant really appears to be arguing is that the Board erred in finding that the injury was not disabling from the outset. That finding is supported by substantial evidence.

Claimant's second and third assignments of error are both based on the erroneous assumption that claimant's aggravation rights are affected by SAIF's failure to close his claim properly. If an injury is properly classified as nondisabling, an aggravation claim must be filed within five years from the *date of injury*. ORS 656.262(12); ORS 656.273;[2] *Smith v. Ridgepine, Inc.*, 88 Or App 147, 744 P2d 586 (1987). Claimant's aggravation rights ran from the date of his nondisabling injury.

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[1] ORS 656.005(8), now ORS 656.005(7)(c) and (d), provided, in part:

"(b) A 'disabling compensable injury' is an injury which entitles the worker to compensation for disability or death.

"(c) A 'nondisabling compensable injury' is any injury which requires medical services only."

[2] ORS 656.262(12), now ORS 656.277(2), provided, in pertinent part:

"A claim that a nondisabling injury has become disabling, if made more than one year after the date of injury, shall be made pursuant to ORS 656.273 as for a claim for aggravation."

ORS 656.273 provided, in part:

"(4)(b) If the injury was nondisabling and no determination was made, the claim for aggravation must be filed within five years after the *date of injury*." (Emphasis supplied.)

Claimant next assigns error to the Board's conclusion that none of the physician's reports filed within five years from the date of his injury constituted an aggravation claim. In *Krajacic v. Blazing Orchards*, 84 Or App 127, 733 P2d 113, *mod* 85 Or App 477, 737 P2d 617, *rem'd* 304 Or 436 (1987), *aff'd* 90 Or App 593, 752 P2d 1299, *rev den* 306 Or 155 (1988), the same issue was raised under the same statutory provisions. We explained:

> "The requirements for an aggravation claim are not rigorous. However, an indication of a changed condition must be made. *Haret v. SAIF*, [72 Or App 668, 672, 697 P2d 201, *rev den* 299 Or 313 (1985)]. ORS 656.273 provides, in part:
>
> 114 Or App 31> "'(1) After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, *for worsened conditions resulting from the original injury.*
>
> "'* * * * *
>
> "'(3) A physician's report indicating a need for further medical services or additional compensation is a claim for aggravation.' (Emphasis supplied.)
>
> "As we noted in *Haret*, the purpose of subsection (3) is to allow an aggravation claim to be made by a physician's report which requests additional services. However, 'additional services' must be read together with ORS 656.273(1). That provision makes clear that the additional medical services referred to are for 'worsened conditions.' While we agree with claimant that the report itself does not need to prove the worsened condition, it must put the insurer on notice that treatment for more than *continuing* conditions is indicated." 84 Or App at 130. (Emphasis in original.)

In this case, the Board concluded that the reports submitted by claimant's physicians within the five-year period after his injury did not put the insurer on notice that claimant's underlying condition had worsened. The reports all indicated that claimant was receiving palliative treatment for his original injury. It was not until December, 1988, after the five-year period had expired, that Ries submitted a report indicating that claimant's condition had worsened. That was too late.[3]

Affirmed.

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[3] In the light of our decision that claimant's aggravation rights had expired before he submitted an aggravation claim, the last assignment of error relating to penalties and attorney fees for unreasonable resistance to payment of aggravation related compensation is moot.

Cite as 114 Or App 64 (1992) July 8, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Alan G. Herron, Claimant.

SAIF CORPORATION and CARLIN CONSTRUCTION, Petitioners - Cross-Respondents,
v.
ALAN G. **HERRON**, Respondent - Cross-Petitioner.
(WCB 90-13623; CA A69754)

In Banc
Judicial Review from Workers' Compensation Board.
Argued and submitted December 11, 1991.
David L. Runner, Assistant Attorney General, argued the cause for petitioners - cross-respondents. With him on the briefs were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Donald M. Hooton, Eugene, argued the cause for respondent - cross-petitioner. With him on the brief were Edward J. Harri and Malagon, Moore & Johnson, Eugene.
WARREN, J.
Reversed and remanded for reconsideration on petition; affirmed on cross-petition.
Durham, J., dissenting.

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114 Or App 66> Employer seeks review of a Workers' Compensation Board order holding that claimant's award of scheduled permanent partial disability (PPD) should be paid at the rate of $305 per degree, pursuant to ORS 656.214(2), as amended by Or Laws 1990, ch 2, 7.[1] We reverse.

Claimant suffered a compensable injury in June, 1989. Employer accepted the claim, and it was closed by a determination order in January, 1990, with an award of 8.10 degrees scheduled PPD. By a stipulated order dated June 4, 1990, claimant was awarded an additional 6.75 degrees scheduled PPD. The Board determined that claimant should be paid $305 per degree for that additional award because of the 1990 amendment to ORS 656.214(2), rather than $145 per degree, which was the rate at the time of the injury.

ORS 656.202(2) provides that,

> "[e]xcept as otherwise provided by law, *payment of benefits for injuries* or deaths under this chapter *shall be* continued as authorized, and *in the amounts provided for, by the law in force at the time the injury giving rise to the right to compensation occurred.*" (Emphasis supplied.)

In May, 1990, the legislature enacted a revision of the workers' compensation laws, including an amendment to ORS 656.214(2) that increased the rate of compensation for scheduled disabilities to $305 per degree.

Oregon Laws 1990, chapter 2, section 54, provides:

> "(1) *Except for amendments to* ORS 656.027, 656.211, 656.214(2) and 656.790, this 1990 Act becomes operative July 1, 1990, *and notwithstanding ORS 656.202*, this 1990 Act applies to all claims existing or arising on and after July 1, 1990, regardless of date of injury, except as specifically provided in this section.

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[1] Department of Insurance and Finance (DIF) has intervened, pursuant to ORAP 4.40, to defend its rule, OAR 436-35-010(5), which provides that the 1990 amendment to ORS 656.214(2) applies only to injuries sustained after the effective date of the amendment. DIF joined in employer's brief and does not raise any independent arguments. We will not separately discuss DIF's position.

> "(2) Any matter regarding a claim which is in litigation before the Hearings Division, the board, the Court of Appeals or the Supreme Court under this chapter, and regarding <114 Or App 66/67> which matter a request for hearing was filed before May 1, 1990, and a hearing was convened before July 1, 1990, shall be determined pursuant to the law in effect before July 1, 1990.
>
> "(3) Amendments by this 1990 Act to ORS 656.214(5), the amendments to ORS 656.268(4), (5), (6), (7) and (8), ORS 656.283(7), 656.295, 656.319, 656.325, 656.382 and 656.726 shall apply to all claims which become medically stationary after July 1, 1990." (Emphasis supplied.)

Section 55 provides:

> "This Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this Act takes effect on its passage."

The parties agree that May 7, 1990, is the date when the law was passed. They also agree that the amendments to ORS 656.214(2) became effective on that date. The issue is whether amended ORS 656.214(2) applies to awards made after the effective date of the amendment, regardless of the date of injury, or whether the applicable rate is the one in effect at the time of the injury.

The Board concluded that section 54 is unambiguous:

> "Section 54(1) consists of two grammatically independent clauses. The first clause establishes the operative date (when those sections become effective) of four particular amended sections, ORS 656.027, 656.211, 656.214(2) and 656.790. The second independent clause establishes the applicability (to which claims the amendments apply) of the entire 1990 Act. Clearly, the subject matter of the two clauses is entirely different. We find no grammatical or logical reason to conclude that a portion of the first independent provision of Section 54(1), *fixing the operative date of four specific sections,* should modify the clearly stated provision controlling *the applicability of the entire 1990 Act.*
>
> "We can discern no other reasonable reading of Section 54(1) than the one we have stated. It is clear, unambiguous and susceptible on its face to only one reasonable reading." (Footnotes omitted.)

Notwithstanding its conclusion that the statute is clear on its face, the Board considered the legislative history and found <114 Or App 67/68> that it was not "clearly contrary to the section's plain meaning." Thus, it concluded that the amendment to ORS 656.214(2) applies to all awards of scheduled disability made on or after May 7, 1990, regardless of the date of injury.

Employer argues that the Board's analysis is grammatically and logically flawed. It asserts that the initial phrase, "[e]xcept for amendments to ORS * * * 656.214(2)," can just as well modify both of the independent clauses: the effective date clause and the applicability clause. It points out the illogic of the Board's reading, which would have the amendment to ORS 656.214(2) apply to any scheduled disability award made after May 7, but not unless the claim continued to exist on July 1.

In construing a legislative enactment, our first task is to discern the legislature's intent. *See* ORS 174.020. If the language is unambiguous, ordinarily we apply it according to its plain meaning, without resort to legislative history. *Satterfield v. Satterfield*, 292 Or 780, 782, 643 P2d 336 (1982). If, however, the legislative purpose is unclear from the language of the enactment, we may consider legislative history as an aid in determining legislative intent. *State v. Leathers*, 271 Or 236, 531 P2d 901 (1975).

We agree with employer that, grammatically, subsection (1) can reasonably be read in more than one way. The initial phrase, "[e]xcept for amendments to * * * ORS 656.214(2)," could modify either the entire sentence or only the first clause, which deals with the operative date of the 1990 act.

Although it is easier to read it in the way that the Board did, it can also be read as employer asserts.[2] Therefore, we turn to the legislative history to determine what the legislature intended by the language that it used.

The first pertinent discussion of sections 54 and 55 was at the May 4, 1990, meeting of the Interim Special <114 Or App 68/69> Committee on Workers' Compensation. Representative Mannix explained changes from an earlier draft to the draft that was finally enacted:

> "I have been advised that there is some--there isn't a change here--changes that--*except for amendments to* [ORS 656].027, [ORS 656].211, [ORS 656].214(2), and [ORS 656].790: *Those provisions are things which the group--Mahonia Hall group wanted to go into effect immediately*--includes the Industrial Advisory Council to go into effect immediately. *They're also using, as an operative date, the standard* that's in .21, excuse me, *that's in* [ORS 656].*202-- the date of injury as the operative date for those provisions.* That--in other words, we're following the standard for that provision and then you jump into, *after that exception, the Act becomes operative July 1 and it applies to all claims existing or arising on or after July 1, regardless of date of injury.* We have the exception for litigation and then we have the exception for, what I'll call claims processing-- where medically stationary date is the provision; that is, you've got an open claim, it becomes medically stationary after July first--then those new laws will kick in. * * * And believe it or not that explanation reflects something that is actually simpler than it was in the original bill." Tape Recording, Interim Special Committee on Workers' Compensation, May 4, 1990, Tape 21, Side B at 192-225. (Emphasis supplied.)

The Board discounted that explanation, because Mannix used the term "operative date" when talking about the amendment to ORS 656.214(2). It concluded that he could not have meant to say "applicability date" instead, because both of those terms have precise legislative meanings. It reasoned that it was not authorized to rewrite legislative history and therefore disregarded that statement. Although neither we nor the Board is at liberty to rewrite legislative history, our task is to determine what the legislature intended by its use of certain words. In context, it is apparent that Mannix merely misspoke when he used the term "operative date" in relation to the four provisions in the exception phrase. He said, "That's in [ORS 656].202--the date of injury as the operative date for those provisions." ORS 656.202 has nothing to do with the operative date of anything, but has *only* to do with the applicability of the law to certain claims. Mannix's explanation of section 54, except for <114 Or App 69/70> his misuse of the term "operative date," indicates that the drafters intended the section to be read as employer asserts.

Mannix again explained the provisions during the House floor debate:

> "Finally, I should mention in terms of the effective dates, we've tried to come up with a three-tiered process here. The law will be effective on passage, but *only four sections are effective immediately and they're subject to the standards of 656.202. Those four sections are 656.027, .211, .214 sub (2), and .790.* Otherwise we have a general clause that says this law will be operative July 1, 1990, with a couple of specific exceptions, one having to do with claims which become medically stationary after July 1, 1990. It allows those claims to then be processed under the new standards. And the other exception is the litigation exception. For once, our legislature has recognized that there are actually tens of thousands of cases in litigation and we're not going to reinvent the wheel on those cases. We will let those cases proceed under the standards in which they were tried, so that you, again, will not be creating more work for lawyers." Tape Recording, House Special Session, Floor Debate, May 7, 1990, Tape 2, Side A at 243-60. (Emphasis supplied.)

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[2] Claimant asserts that the final phrase of subsection (1), "except as specifically provided in this section," somehow clarifies that the legislature intended the opening exception phrase to apply only to the operative date clause. We are not persuaded. The final phrase could be an indication that the *only* exceptions to the applicability clause are the two exceptions that follow that language, contained in subsections (2) and (3). However, it could also be an acknowledgment of the exceptions in subsections (2) and (3) *and* the exception in the initial phrase of subsection (1). The phrase does nothing to clarify the legislature's intent.

The emphasized statement makes clear that the amendments that were to be effective immediately on passage, including the amendment to ORS 656.214(2), are subject to the date of injury rule of ORS 656.202 and that the remainder of the amendments generally will be "operative" July 1. Mannix used the term "operative" in a way that is consistent with the language of section 54 but then said that the operative date is subject to two specific exceptions: subsections (2) and (3). Subsections (2) and (3) relate only to the applicability of the new act to certain claims; they have nothing to do with the operative date of the new act. Thus, although Mannix's language was inaccurate, it is possible for us to glean his meaning.

Finally, during the Senate floor debate, Senator Kitzhaber said:

> "The Act becomes operative July first, 1990 for all claims existing or arising on or after that date, regardless of the date of injury, except any claim already being heard in the Hearings Division or before the Board or courts which was filed before May first and had a hearing before July first shall be <114 Or App 70/71> determined under the prior or existing law. The new earning capacity definition, the full application of the standards, the new procedures for terminating time loss, rating of impairment, including the medical arbiters, the reconsideration process and the independent medical evaluations shall apply to all claims which become medically stationary after July first of 1990. *Section 55 makes all other sections of the bill, including* the labor-management committee provisions and *the increase in scheduled permanent partial disability, go into effect upon passage of the bill and will apply to injuries which occur after the effective date of this Act.*" Tape Recording, Senate Special Session, Floor Debate, May 7, 1990, Tape 3, Side A at 79-92. (Emphasis supplied.)

That statement, too, consistently shows an intent to apply the increase in scheduled disability only to injuries that would occur after the effective date of the act, May 7, 1990. However, the Board also found fault with Kitzhaber's comments, saying that they contradicted statements by Mannix and what it considered the clear language of section 54(1). We have already said that section 54(1) is not clear. Furthermore, we see no contradiction between the legislators' statements. Kitzhaber said that, under section 55, the act was to become effective immediately on passage. Pursuant to section 54, however, only four amendments were to become operative on that date. Those amendments, he explained, were to apply to injuries that occur after the effective date of the act. He explained that the amendments that would become operative on July 1 would apply to all claims existing on that date, regardless of the date of injury rule in ORS 656.202. That reading of sections 54 and 55 is consistent with Mannix's explanations.[3]

Our reading makes all parts of section 54 reasonable and harmonious. *See Cal-Roof Wholesale v. Tax Com.*, 242 Or <114 Or App 71/72> 435, 443, 410 P2d 233 (1966); *Rivers v. SAIF*, 45 Or App 1105, 1108, 610 P2d 288 (1980). First, all of the provisions that became operative on July 1, 1990, which includes all amendments other than those excepted by the initial phrase of subsection (1), apply to claims existing or arising on and after that same date, July 1, except as provided in subsections 54(2) and (3). The amendments that became operative May 7 are subject to ORS 656.202, which requires application of the law that existed at the time of the compensable injury. Thus, a scheduled disability resulting from an injury that occurred on or after May 7 will be compensated at $305 per degree, but an injury that occurred before May 7 will be compensated at the old, lower rate.

That reading also harmonizes with subsection 54(2). Whether or not "the law in effect before July 1," referred to in that subsection, was intended to include the amendments that became effective

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[3] The Board also noted that

> "[s]ome of the sections which are subject to the exception created by the first clause of Section 54(1), ORS 656.211 and 656.790, are purely administrative in nature. They have nothing to do with a particular *claim* and, therefore, ORS 656.202 and the dates of injury of a claim are irrelevant to those sections. In other words, the subject matter of the second clause of Section 54(1) has no bearing on ORS 656.211 and 656.790." (Emphasis in original.)

Even if that were so, it would not mean that the first phrase cannot modify the entire sentence. It merely means that the applicability date clause of the sentence is irrelevant to the two amendments that are unrelated to claims.

May 7, our reading of subsection 54(1) consistently applies the law in effect on the date of injury for cases in litigation and for determining the rate of compensation for all other awards of scheduled disability, whether made before, on or after May 7.

We conclude that the legislature intended the date of injury rule of ORS 656.202 to apply to the amendment to ORS 656.214(2), so that the increased rate of compensation applies only to injuries that occurred on or after May 7, 1990. Claimant is entitled to be paid PPD at the rate in effect as of the date when he was injured, $145.

Because of our disposition of the petition, we need not address claimant's cross petition.

Reversed and remanded for reconsideration on petition; affirmed on cross-petition.

DURHAM, J., Dissenting.

The majority rejects the Board's conclusion that Oregon Laws 1990, chapter 2, section 54, is "clear, unambiguous and susceptible on its face to only one reasonable reading." The majority's conclusion that the statute is ambiguous leads it to explore legislative history, and that history leads it to adopt an interpretation of the statute which, in my view, is contrary to its terms. The majority <114 Or App 72/73> orders the Board to direct employer to compensate claimant for his increased scheduled permanent partial disability at $145 per degree, the rate in effect when he was injured in 1989, rather than $305 per degree, the rate in effect in June, 1990, when the additional permanent partial disability was ordered. I respectfully dissent.

The majority mistakes complexity for ambiguity. The statute manifests the legislature's intention with sufficient clarity that a resort to legislative history is not appropriate. *See McKean-Coffman v. Employment Div.*, 312 Or 543, 549, 824 P2d 410 (1992); *Whipple v. Howser*, 291 Or 475, 632 P2d 782 (1981).

Or Laws 1990, ch 2, 54, provides:

> "(1) *Except for amendments to* ORS 656.027, 656.211, 656.*214(2)* and 656.790, this 1990 Act becomes operative July 1, 1990, *and notwithstanding ORS 656.202, this 1990 Act applies to all claims existing or arising on and after July 1, 1990, regardless of date of injury,* except as specifically provided in this section.
>
> "(2) Any matter regarding a claim which is in litigation before the Hearings Division, the board, the Court of Appeals or the Supreme Court under this chapter, and regarding which matter a request for hearing was filed before May 1, 1990, and a hearing was convened before July 1, 1990, shall be determined pursuant to the law in effect before July 1, 1990.
>
> "(3) Amendments by this 1990 Act to ORS 656.214(5), the amendments to ORS 656.268(4), (5), (6), (7) and (8), ORS 656.283(7), 656.295, 656.319, 656.325, 656.382 and 656.726 shall apply to all claims which become medically stationary after July 1, 1990." (Emphasis supplied.)

Section 55 provides:

> "This Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this Act takes effect on its passage."

Subsection (1) of section 54 is divided into two clauses. The first is the "operative date" clause ("Except for amendments to ORS 656.027, 656.211, 656.214(2) and 656.790, this 1990 Act becomes operative July 1, 1990 * * *."). The second is the "applicability" clause ("and notwithstanding ORS 656.202, this 1990 Act applies to all claims <114 Or App 73/74> existing or arising on and after July 1, 1990, regardless of date of injury, except as specifically provided in this section"). The purpose of the operative date clause is to make the 1990 Act operative on July 1, 1990, except for amendments to four specified statutes, including one to ORS 656.214(2) that raised the rate for each degree of scheduled

disability from $145 to $305. As a result of the exception of ORS 656.214(2), the rate increase amendment became effective on May 7, 1990, by operation of the emergency clause section 55.

The applicability clause describes the claims to which the 1990 Act applies. It was necessary because, without it, the 1990 Act would be governed by ORS 656.202, which provides that, except as otherwise provided by law, claims are governed by the law in effect on the date of injury. The applicability clause expressly changes that rule with respect to the 1990 Act and declares that the new law

> "applies to all *claims existing or arising on and after July 1, 1990, regardless of the date of injury,* except as specifically provided in this section." (Emphasis supplied.)

The operative date clause and the applicability clause address different topics, perform distinct functions and cannot be grammatically or logically blended. The majority errs in holding that the operative date clause can be read to modify the entirety of subsection (1). That construction defeats the legislature's separation of the two clauses. As a result, the majority concludes that the increased payment amendment to ORS 656.214(2), which is excepted from the coverage of the operative date clause, is governed by the "date of injury" rule in ORS 656.202(2), because that rule is excepted from the coverage of the applicability clause ("and notwithstanding ORS 656.202"). However, ORS 656.214(2) is not excepted from the coverage of the applicability clause, and that clause applies by its literal terms "to all claims existing * * * on * * * July 1, 1990, *regardless of the date of injury.*" (Emphasis supplied.) This claim meets that description.

The majority's blending of the two clauses does not result in a plausible statutory construction. The operative date clause excepts four statutes, not just one, from the coverage of that clause. The other three statutes, ORS 656.027, ORS 656.211 and ORS 656.790, address administrative topics and have nothing to do with an individual claim. <114 Or App 74/75> The Board concluded that construing those sections to be subject to ORS 656.202 would be "tantamount to rewriting the legislation," and I agree.

The majority turns to legislative history to discern legislative intent, but the history displays far greater ambiguity than the statute itself.

The majority quotes statements on May 4 and 7, 1990, by Representative Mannix, and a May 7, 1990, statement by Senator Kitzhaber. An examination of each discloses that they are internally inconsistent.

A portion of the May 4, 1990, statement by Mannix is quoted in the majority opinion. The complete statement by Mannix was addressed by the Board in its order. He stated:

> "I have been advised that there is some--there isn't a change here--changes that--except for admendments to [ORS 656].027, [ORS 656].211, [ORS 656].214(2), and [ORS 656].790: Those provisions are things which the group--Mahonia Hall group wanted to go into effect immediately--includes the Industrial Advisory Council to go into effect immediately. They're also using, as an operative date standard that's in .21, excuse me, that's in [ORS 656].202--the date of injury as the operative date for those provisions. That--in other words, we're following the standard for that provision and then you jump into, after that exception, the Act becomes operative July 1 and it applies to all claims existing or arising on or after July 1, regardingless of date of injury. We have the exception for litigation and then we have the exception for, and I'll call claims processing--where medically stationary date is the provision; that is, you've got an open claim, it becomes medically stationary after July first--then those new laws will kick in. * * * And believe it or not that explanation reflects something that is actually simpler than it was in the original bill.
>
> "*You're going to have three factors: effective date immediately, the administrative procedures, as far as the advisory counsel goes, and the provisions in regard to [ORS 656].027, [ORS 656].211, [ORS 656].214 sub (2) and [ORS 656].790. And then, as of July first, it'll apply to all claims,* with one more exception, and that is, if there are some claims that are not yet medically stationary, and those will kick in when they become medically

> stationary after July first." Minutes, Joint Interim Special Committee (SB 1197). Tape 19A (May 4, 1990)." (Emphasis supplied.)

114 Or App 76> As the Board points out, the first three sentences by Mannix support the Board's construction of section 54(1). In his fourth sentence, Mannix used the term "operative date" twice to suggest that the four statutes excepted from the coverage of the operative date clause are governed by the "date of injury" standard in ORS 656.202. The majority suggests that Mannix "merely misspoke" in using the term "operative date." There is more here than erroneous terminology. Mannix's comment confuses the effect of the operative date clause with that of the applicability clause. The majority finds that Mannix employed his misstatement consistently, but that is inaccurate. His last two sentences contradict the passage relied on by the majority, revert to the construction that he offered in his first three sentences and support the interpretation adopted by the Board. Mannix said that "administrative procedures" and "the provisions with regard to .027, .211, *.214(2)* and .790" (emphasis supplied) would take effect "immediately." That clearly indicates that, according to Mannix, the rate increase amendment in ORS 656.214(2) would take effect "immediately," *i.e.*, on May 7, 1990. His final sentence ("then, as of July 1, it will apply to all claims * * *") confirms that the legislation would apply to all claims and, in the words of the statute under consideration, that meant "all claims *existing* or arising *on and after July 1, 1990, regardless of date of injury,* except as specifically provided in this section." (Emphasis supplied.)

Mannix's May 7, 1990, statement contains similar conflicting signals. His third and fourth sentences are significant:

> "The law will be effect on passage, but only four sections are effective immediately and they're subject to the standards of 656.202. Those four sections are 656.027, .211, 214(2) and .790."

The Board examined the statement and commented:

> "That suggests, as SAIF argues, that another 'applicability date' may have been intended. However, it remains unclear if that is what was meant and, if so, why two of those four sections should be excluded from the operation of a statute (ORS 656.202) which would have no bearing upon their applicability."

114 Or App 77> I agree. The "date of injury" rule in ORS 656.202 is logically unrelated to the administrative amendments excepted from the operative date clause.

Mannix then said: "We will let those cases proceed under the standards in which [sic] they were tried, so that you, again, will not be creating more work for lawyers." The majority concludes that that indicates that the new rate enacted in ORS 656.214(2) was to be "subject to the date of injury rule of ORS 656.202 and that the remainder of the amendments generally will be 'operative' July 1." 114 Or App at 70. The majority makes an unwarranted leap of faith because the words of the bill that Mannix purported to describe provided that the bill would apply to "all claims existing or arising on or after July 1, 1990, *regardless of date of injury,* except as specifically provided in this section," (emphasis supplied) and that it would apply "notwithstanding ORS 656.202." Mannix's statement that the new act would be subject to the date of injury rule in ORS 656.202 contravenes each of the legislature's two clear signals that the act would apply "notwithstanding 656.202" to claims existing on July 1, 1990, "regardless of date of injury." Those statutory provisions defeat, or at the least conflict with, any suggestion that the 1990 Act was to apply only to injuries occurring on and after May 7, 1990.

The May 7, 1990, statement by Kitzhaber, 114 Or App at 70-71, is similarly ambiguous and inconsistent with the terms of section 54(1). The first sentence recites part of the applicability clause, stressing that the act becomes operative on July 1, 1990, "for all claims existing or arising on or after that date, regardless of the date of injury," subject to stated exceptions. However, his last sentence contradicts that, suggesting that the amendment to ORS 656.214(2) would "go into effect upon passage of the Bill and will apply to injuries which occur after the effective date of this Act." I agree with the Board that the latter statement contradicts his earlier statement, the first quoted statement by Mannix and the unambiguous language of the applicability clause of section 54(1). I cannot understand how the majority derives a clear legislative intention from testimony that is internally inconsistent and contrary to the clear terms of the legislation under consideration.

114 Or App 78> Finally, the majority suggests that its construction "harmonizes" all of section 54. I disagree. Sections 54(2) and (3) state exceptions to the applicability clause of subsection (1), in correlation with its final clause ("except as specifically provided in this section"). Subsection (2) declares that claim litigation in progress with two procedural characteristics (request for hearing filed before May 1, 1990, and hearing convened before July 1, 1990) "shall be determined pursuant to the *law in effect before July 1, 1990.*" (Emphasis supplied.) The majority disregards the significance of the italicized words, stating:

> "Whether or not 'the law in effect before July 1," referred to in that subsection, was intended to include the amendments that became effective May 7, our reading of subsection 54(1) consistently applies the law in effect on the date of injury for cases in litigation and for determining the rate of compensation for all other awards of scheduled disability, whether made before, on or after May 7." 114 Or App at 72.

Contrary to the majority's conclusion, the legislature's phrase, "the law in effect before July 1," is not synonymous with "the law in effect on the date of injury." If the legislature had wanted the "date of injury rule" in ORS 656.202 to control in pending litigation, it could have said so by citing that statute, by requiring application of the law in effect "before May 7, 1990," or by words to that effect. It did not do so.

The "law in effect before July 1, 1990," necessarily includes those amendments made effective on May 7, such as the amendment to ORS 656.214(2). That phrase indicates that the legislature intended the greater PPD rate to apply to pending litigation, even though it was not the "law on the date of injury." That is consistent with the purpose of subsection (2) to save the parties the expense and frustration of applying the 1990 amendments, including changes in claim procedures and proof requirements, *see, e.g.*, Or Laws 1990, ch 2, 3, 10, 15, 16, 18, 20, 22, and 40, to certain claims in litigation or on appeal. Applying the new PPD rate to those claims would not change the hearing ground rules or proof requirements or disrupt parties' discovery activities or litigation strategy.

114 Or App 79> Subsection (3) limits the application of several amendments to "all claims which become medically stationary after July 1, 1990." The amendments alter the procedures or criteria for certain medical determinations. As with subsection (2), the legislature's purpose in altering the applicability date for those amendments was to avoid the unfairness of applying new procedures and criteria to claims for which the underlying injury had become medically stationery on or before July 1, 1990.

Subsections (1), (2) and (3), taken together, manifest a legislative intention to apply the 1990 amendments to existing claims, "notwithstanding ORS 656.202" and "regardless of the date of injury," but not to allow that to disrupt pending litigation. The majority violates that intention by preserving the date of injury rule for awards of scheduled disability for pre-May 7, 1990, injuries to an extent not necessary to protect parties from after-the-fact changes in the standards governing their pending claims. That does not harmonize the subsections and violates the traditional rule that exceptions to statutory requirements are narrowly construed. *Morrison v. School Dist. No. 48*, 53 Or App 148, 152, 631 P2d 784, *rev den* 291 Or 893, 642 P2d 309 (1981). The Board's construction produces consistency between sections 54(1), (2) and (3), and must be preferred for that reason.

We are bound to apply the clear terms of the statute, regardless of competing inferences that may be developed through an exploration of legislative history. The Board correctly held that the amendment to ORS 656.214(2) applied to this claim, because it existed on July 1, 1990. The Board should be affirmed as to the rate of compensation that it ordered.[4]

I dissent.

Buttler, Rossman and Riggs, JJ., join in this dissent.

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[1] Respondent Herron has cross-petitioned for review of the Board's award of attorney fees. Because I would affirm the Board, on the petition for review, I would address the merits of the cross-petition.

Cite as 114 Or App 117 (1992) July 8, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Les S. Epstein, Claimant.

ATLAS CYLINDER and CONTINENTAL LOSS ADJUSTING SERVICES, Petitioners,
v.
LES S. **EPSTEIN**, Respondent.
(88-09104; CA A67014)

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.
Karen M. Werner, Eugene, argued the cause for respondent. With her on the brief were Thomas Cary and Coons, Cole & Cary, P.C., Eugene.
Before Richardson, Presiding Judge, and Joseph, Chief Judge, and Deits, Judge.
DEITS, J.
Award of attorney fees and penalty vacated; otherwise affirmed.

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114 Or App 119> Employer seeks reversal of a Workers' Compensation Board order that held that claimant is entitled to temporary partial disability benefits, assessed a penalty against employer for unreasonable failure to pay benefits and awarded claimant attorney fees. Employer contends that the Board improperly considered the issue of compensability of claimant's psychological condition, that it did not apply the proper standard of proof and that it erred in assessing a penalty and awarding attorney fees.

Claimant, a maintenance worker, compensably injured his back on October 1, 1987, while lifting a heavy barrel. Employer accepted the claim as a disabling injury. Claimant was anxious to return to work, so he obtained a release from his treating physician to return to modified work on October 12, 1987. After that, he missed work many times for reasons related to the injury. On April 7, 1988, he was fired for excessive absenteeism and insubordination immediately after he responded in an obnoxious manner to a supervisor who had instructed him to return to his work station. He was later treated by a psychiatrist, who diagnosed an adult adjustment reaction with depression.

After his termination, claimant sought temporary partial and temporary total disability, but employer denied the claim. After a hearing on August 25, 1988, the referee concluded:

> "Claimant's psychological state was a material contributing factor in his insubordination and absenteeism. Also, claimant's compensable physical back condition was a material contributing factor in claimant's excessive absenteeism from October 1987 to April 1988. Claimant was not terminated for reasons unrelated to his compensable injury."
>
> "Claimant was subjected to repeated criticism by the employer regarding his absenteeism and job performance over the period of modified work prior to his termination."

The referee also determined that employer knew that much of claimant's absenteeism was related to the compensable back condition, that his claim had not been closed and that he was not medically stationary when he was terminated. The referee concluded that the failure to pay temporary partial <114 Or App 119/120> disability compensation after the termination was unreasonable.

Employer first contends that, because neither claimant's original request for hearing and specification of issues nor his supplemental request raised the issue of a compensable mental condition, the Board improperly considered the issue of compensability of claimant's psychological condition. As stated in the referee's opinion, adopted by the Board:

"The instant underlying original claim is one for disabling accidental injury. There is no occupational disease claim presented for claimant's psychological state. The contention regarding the psychological state is that it is a sequela of the compensable back injury."

We agree with the Board that the claim was for benefits for the consequences of a compensable injury, rather than an independent claim for an injury or an occupational disease. *Boeing Co. v. Viltrakis*, 112 Or App 396, 398, 829 P2d 738 (1992); *see Morrow v. Pacific University*, 100 Or App 198, 201, 785 P2d 787 (1990). The psychological consequences of the injury were properly presented at the hearing and were not a "separate issue," as employer asserts.[1]

Employer also argues that, even if the psychological condition was related to the injury, claimant bore the burden of proving that his employment was the major contributing cause of the mental condition under ORS 656.802(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.

114 Or App 121> "(d) Unless there is clear and convincing evidence that the mental disorder arose out of and in the course of employment."

ORS 656.802, however, does not apply where the claim is for a condition that is the consequence of a compensable injury. As we explained in *Boeing Company v. Viltrakis, supra*, 112 Or App at 399:

"[W]hen 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. * * * To establish entitlement to benefits for treatment of symptoms of stress that were brought about by [a] compensable injury, a claimant need only show that the compensable injury is a material contributing cause of the condition requiring treatment."[2] (Citations omitted.)

The Board found that the injury was a material contributing cause of the mental condition, and that was the proper standard under these circumstances. *See SAIF Corporation v. Hukari*, 113 Or App 475, 480, ___ P2d ___ (1992).

Employer argues that there is no substantial evidence to support the conclusion that the mental condition resulted from the compensable injury. We conclude that there is substantial evidence. A

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[1] Because of our conclusion that the claim was a natural consequence of claimant's back injury rather than a separate claim for a mental disorder, it is unnecessary to address employer's argument that the mental condition claim was premature because it had not yet denied the claim; its argument that, because 60 days had not passed, it had not denied the claim *de facto*; or its contention that the referee did not have to decide whether claimant's mental condition was compensable.

[2] Since the referee's hearing in this case, 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." Or Laws 1990, ch 2, 3.

That is not applicable here, because the hearing was before July 1, 1990. Or Laws 1990, ch 2, 54(2).

psychiatrist diagnosed claimant's psychological state as an adult adjustment reaction with depression. His report reads:

> "The most outstanding feature of the mental status exam was the intense affective state of this individual. Especially when talking about the incident of his dismissal and the events leading to it. It would appear that this patient visualizes what has occurred in the following manner. He sees himself as having returned to work as early as possible for the convenience of the employer where he was injured. He sees himself putting forth a maximum that he could with his physical limitations and experienced a change in management of the facility of which he worked. He then experienced <114 Or App 121/122> what he considered a total disregard for his devotion to his work. He was particularly friendly with his immediate supervisor, Walt, and he experienced rejection from him when he was terminated. He concludes that Walt was under a great deal of pressure also because of the changes in management. The patient appeared to be despondent, agitated and when describing dates of the past several months he experienced blocking to the point he was unable to speak for 1-5 minutes, and then did not regroup and organize. Other than this he showed no evidence of schizophrenic reaction, dementia, delerium [sic], mental retardation or mania."

The psychiatrist testified that symptoms of claimant's mental and physical condition increased as a response to his belief that employer was intolerant of his injuries. We conclude that there was substantial evidence to support the Board's findings that the injury was a material contributing cause of the mental condition.

Employer finally assigns error to the Board's assessment of a penalty and attorney fees against the insurer. ORS 656.262(1) provides:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

If an employer has a legitimate doubt about its liability for workers' compensation, its refusal to pay is not unreasonable. *International Paper Co. v. Huntley*, 106 Or App 107, 110, 806 P2d 188 (1991). Here, at the time when the time loss was denied, employer had a legitimate doubt about its liability. Claimant had been missing work regularly, had been placed on probation and had been insubordinate. He did not seek psychiatric treatment until after he had been fired. Employer was not informed of the mental aspects of the injury claim until shortly before the hearing on the denial. We conclude that the Board erred in assessing a penalty and awarding attorney fees.

Award of attorney fees and penalty vacated; otherwise affirmed.

Cite as 114 Or App 151 (1992) July 8, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Adelbert P. Sheppard, Claimant.
ADELBERT P. **SHEPPARD**, Petitioner,
v.
KAISER CEMENT CORPORATION, S.I.M.S., RIEDEL INTERNATIONAL, FARMERS INSURANCE and AIAC, Respondents.
(WCB 85-01687; 85-01770; 85-01769; CA A70695)

Judicial Review from Workers' Compensation Board.
Argued and submitted May 20, 1992.
Kevin Keaney, Portland, argued the cause for petitioner. With him on the brief were Robert K. Udziela and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.
Joanne W. Mills, Portland, argued the cause for respondents Kaiser Cement Corporation and S.I.M.S. On the brief were Brian M. Perko, Karen O'Kasey and Schwabe, Williamson & Wyatt, Portland.
Jay W. Beattie, Portland, argued the cause for respondents Riedel International and AIAC. With him on the brief was Lindsay, Hart, Neil & Weigler, Portland.
John L. Klor and Wallace & Klor, Portland, waived appearance for respondent Farmers Insurance.
Before Riggs, Presiding Judge, and Edmonds and De Muniz, Judges.
RIGGS, P.J.
Affirmed.

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114 Or App 153> Claimant seeks review of an order of the Workers' Compensation Board affirming the referee's dismissal of his claim for failure to comply with a pre-hearing order requiring discovery. We affirm.

Claimant sought a hearing on employer's denial of a claim for hearing loss. After claimant filed his claim, his counsel wrote to his treating physician, Dr. Milligan. The letter, dated March 13, 1986, stated:

> "As you know, my firm represents Mr. Sheppard in his claim for workers' compensation benefits based on his hearing loss. By this letter, I am requesting that you not have any communication by telephone or by letter with any attorney representing any insurance company in regard to Mr. Sheppard's workers' compensation claim. Mr. Sheppard has a right to confidentiality with his physician and I am asking that you honor that. If you should be contacted by any representative with the insurance company, I would ask that you let me know."

After the letter was sent to Milligan, counsel for one of the insurers (AIAC) attempted to discuss claimant's condition with the doctor. After Milligan refused to discuss his treatment, the insurer obtained an order for discovery. The order provided:

> "Whereas the parties have requested a ruling on defendant's April 4, 1986 letter motion to allow it to speak with claimant's doctor, Now Therefore IT IS ORDERED:
>
> "1) Defendant is allowed unrestricted access to claimant's doctor or doctors;
>
> "2) If claimant does not comply within 90 days of the date of this order defendant may move for dismissal."

After receiving the discovery order, claimant's counsel had no further contact with Milligan. More precisely, claimant's counsel did not advise Milligan of the discovery order or in any other way attempt to rescind his letter asking Milligan to refuse access. Ninety-two days after the referee issued the discovery order, insurer's counsel again tried to speak with Milligan, without success. The insurer then moved to dismiss the request for hearing, because claimant had failed to comply with the order

allowing discovery. The <114 Or App 153/154> referee allowed the motion to dismiss, and the Board affirmed.

At issue is whether the Board correctly applied the Board's own rule in finding that claimant's counsel "occasioned delay" without "good cause," in violation of OAR 438-06-085. In *Mershon v. Oregonian Publishing,* 96 Or App 223, 226, 772 P2d 440, *rev den* 308 Or 315 (1989), we accepted the Board's interpretation of OAR 438-06-085 that "a prehearing delay in discovery occasioned by a claimant's failure to comply with an order allowing discovery is a ground for dismissal for want of prosecution."

We must affirm the Board if we find that it reasonably concluded that claimant failed to comply with the discovery order by not instructing his physician to respond to inquiries from insurers' counsel. It is on this point that claimant urges us to distinguish *Mershon v. Oregonian Publishing, supra.* Claimant argues that, unlike in *Mershon,* he did absolutely nothing after receiving the referee's discovery order to hinder the efforts of the insurer to obtain information from Milligan. Indeed, this case is factually different from Mershon. Unlike this case, the claimant in Mershon, after receiving the discovery order, continued to insist that the claimant's attorney be present whenever representatives of the insurer met or talked with the treating physician.

In this case, the referee's order, which was adopted and supplemented by the Board, made this finding:

> "(7) The claimant obstructed AIAC's right to speak *ex parte* with Dr. Milligan at, and before the time of the undersigned's original dismissal order dated August 11, 1986, (Ex. 7)."

The referee's order continued:

> "The disputed order was directed to claimant who created the impasse by instructing the doctor not to communicate with defense counsel. This admonition to the doctor was never retracted. It should have been retracted by claimant's letter of equal status with claimant's original March 13, 1986 letter. Sending the doctor a copy of the April 29, 1986 order by the claimant may have solved the problem but that was not done. The claimant's own letter would have taken the burden off of the doctor whose job is to cure not advocate. A telephone call to the doctor would maybe, in his opinion, not <114 Or App 154/155> have protected him at all. There was a contractual relationship, a doctor-patient relationship, between claimant and the doctor. There was no legal relationship between the insurance carrier and the doctor. There was no duty upon the insurance carrier to provide the doctor with a copy of the order. Although the carrier tried, there was no duty to advise the doctor even by telephone of the existence of the order. That was claimant's duty.
>
> "The order was directed to the claimant unrestricted access to claimant's doctor. Unrestricted access could not be had until the March 13, 1986 letter was revoked, which never has been done. The claimant did not comply with the referee's April 29, 1986 order. The dismissal followed."

In its order on review, the Board said:

> "Under the circumstances, we find that Dr. Milligan's continued unwillingness to speak to AIAC's counsel on July 30, 1986 was due to the March 13, 1986 letter, and was not a reflection of his personal desire not to have a conference with AIAC's counsel. We further find that, inasmuch as claimant's counsel had authored the March 13, 1986 letter denying access, it was incumbent upon claimant's counsel to advise Dr. Milligan that the March 13, 1986 letter was withdrawn, thereby leaving it as a matter of personal discretion on the part of Dr. Milligan whether or not to speak to AIAC's counsel.
>
> "Inasmuch as claimant's counsel took no affirmative action to rectify the situation, we further find that the Referee's Order on Motion was not complied with

within the 90 day period. Thus, we conclude that claimant's counsel's failure to take affirmative action to withdraw the March 13, 1986 letter occasioned a prehearing delay."

It is clear that the Board determined that the nonaction of claimant in failing to retract the March 13, 1986, letter to Milligan had the same effect as the type of obstruction addressed in *Mershon*. Notwithstanding the factual differences between *Mershon* and this case, we cannot say that the Board's application of OAR 438-06-085 is unreasonable or inconsistent with the language of the rule or its earlier interpretation. Therefore, we cannot say that the Board erred in affirming the dismissal order.

Affirmed.

Cite as 114 Or App 203 (1992) July 8, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Roy W. Riggs, Claimant.

INTERNATIONAL PAPER COMPANY, Petitioner,
v.
ROY W. **RIGGS**, INDUSTRIAL CARBIDE TOOLING and LIBERTY NORTHWEST INSURANCE CORPORATION, Respondents.
(89-17132, 90-01259; CA A70511)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 16, 1991.
Paul L. Roess, Lake Oswego, argued the cause and filed the brief for petitioner.
Karen M. Werner, Eugene, argued the cause for respondent Roy W. Riggs. On the brief were Thomas M. Cary and Coons, Cole & Cary, Eugene.
David O. Wilson, Eugene, argued the cause for respondents Industrial Carbide Tooling and Liberty Northwest Insurance Corporation. With him on the brief was Employers' Defense Counsel, Eugene.
Before Richardson, Presiding Judge, and Deits and Durham, Judges.
DURHAM, J.
Affirmed.

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114 Or App 205> International Paper Company (International) seeks review of an order of the Workers' Compensation Board that set aside its denial of claimant's aggravation claim and awarded him compensation and attorney fees. We affirm.

In May, 1982, claimant compensably injured his back while setting chokers as a logger for International. Thereafter, he had recurrent back and leg pain. In January, 1986, surgeons performed a spinal fusion. In 1987, he began to work for Industrial Carbide (Carbide) as a saw filer. In August, 1989, a determination order awarded 30 percent unscheduled permanent partial disability. In October, 1989, he again experienced back pain and filed an aggravation claim with International, which denied responsibility and joined Carbide, which also denied responsibility. Claimant requested a hearing. The referee found that International is responsible. International appealed to the Board.

The Board found that claimant's work at Carbide did not worsen his condition and concluded that International remains responsible. International assigns error to that conclusion. It argues that no substantial evidence supports the finding that claimant's work at Carbide did not worsen his back condition. It also asserts that the Board failed to explain how the facts that it found support its conclusion.

Claimant has had ongoing radiculopathy since 1982 and had to stand for roughly eight hours a day while working for Carbide. His back pain increased in October, 1989, caused by pressure on the nerve root. International argues that the increased pressure means that the underlying condition worsened. However, claimant's medical evidence is that radiculopathy may result from a trauma to the nerve, not necessarily from pressure alone, that his spinal fusion was solid, that no other abnormalities

existed, that he had lost no strength since July, 1989, and, according to a treating physician, that that was a good indicator that the underlying condition had not changed. Claimant's chiropractor's diagnosis is that he has had no increased permanent impairment. That was substantial evidence to support the Board's finding that the work at Carbide did not worsen the condition. ORS <114 Or App 205/206> 183.482(8)(c). Moreover, the Board's order recited the medical evidence, and it adequately explained how its findings support its conclusion.

International also assigns error to the Board's award of attorney fees to claimant. It asserts that claimant sought to shift responsibility to Carbide and argues that, because he failed, he did not prevail.

Attorney fees awards in workers' compensation cases must be as authorized by statute. *Forney v. Western States Plywood*, 297 Or 628, 632, 686 P2d 1027 (1984). The Board awarded fees after the hearing because, according to it, claimant's attorney had to participate in the hearing to protect against an assertion of non-compensability. We agree. International and Carbide had both denied responsibility, and neither had conceded that the claim for medical services was compensable. ORS 656.307(1). Compensability could have been an issue at the hearing, had International or Carbide attempted to defeat the claim for medical services by challenging compensability. That reasonably lead claimant's attorney to participate in the hearing. *See SAIF v. Bates*, 94 Or App 666, 669, 767 P2d 87 (1989). The Board did not disallow or reduce claimant's compensation and, therefore, it did not err in awarding attorney fees for the hearing under ORS 656.382(2).[1]

The Board also awarded fees for services rendered on Board review. A claimant is entitled to attorney fees under ORS 656.382(2) if his compensation is put at risk of reduction by the employer's appeal. The Board said:

> "In the present case, claimant's wage rate with the employer was higher than his wage rate at Industrial. Consequently, if responsibility were reassigned on Board review, claimant's temporary disability would be reduced. [Citations omitted.] Because claimant's compensation was at risk of <114 Or App 206/207> reduction as a result of the employer's appeal, claimant's counsel is entitled to an assessed fee."

Employer argues that a fee award is "anomalous," because claimant argued, as did International, that Carbide should be held responsible and that argument was not successful. Notwithstanding any anomaly, the Board was correct. International's appeal placed claimant's award at risk of a reduction, and the Board ruled that the compensation allowed should not be reduced. ORS 656.382(2) authorized the award. Nothing in the statute suggests that a claimant's right to fees depends on the Board's adoption of his arguments. The Board may take into account the claimant's pursuit of unsuccessful arguments in determining what fee is reasonable, but International makes no argument that the fee awarded, $100, is unreasonable.

Affirmed.

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[1] ORS 656.382(2) provides:

> "If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the referee, board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in an amount set by the referee, board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal."

Cite as 114 Or App 344 (1992) July 22, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Frances R. Keenon, Claimant.

FRANCES R. **KEENON**, Petitioner,
v.
EMPLOYERS OVERLOAD; SAIF CORPORATION; HOODY CORPORATION; and LIBERTY NORTHWEST INSURANCE CORPORATION, Respondents.
(WCB 90-01740; 89-25793; 89-25794; 90-01739; CA A70448)

Judicial Review from Workers' Compensation Board Arbitrator.

Argued and submitted February 13, 1992.

Richard A. Sly, Portland, argued the cause and filed the brief for petitioner.

Thomas E. Ewing, Assistant Attorney General, Salem, argued the cause for respondents Employers Overload and SAIF Corporation. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

M. Kathryn Olney, Portland, waived appearance for respondents Hoody Corporation and Liberty Northwest Insurance Corporation.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.

Remanded for reinstatement of attorney fees award for services rendered before issuance of order designating paying agent; otherwise affirmed.

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114 Or App 346 > Claimant seeks review of an order of the Workers' Compensation Board that reversed the decision of a referee, acting as an arbitrator pursuant to ORS 656.307. She argues that the arbitrator correctly awarded her attorney fees and that the Board erred in reversing the award. Although the petition is from an order of the Board, we review the *arbitrator's* decision for errors of law. ORS 656.307(2). We accept SAIF's concession that attorney fees should have been allowed for services rendered before the Department of Insurance and Finance issued an order designating a paying agent under ORS 656.307, and we remand for reinstatement of the award for those services. However, we conclude that claimant is not entitled to attorney fees for participation in the arbitration proceeding after the order designating a paying agent was issued.

Attorney fees for a claimant's participation in an arbitration hearing are governed by 656.307(5):

> "The claimant shall be joined in any proceeding under this section as a necessary party, but may elect to be treated as a nominal party. If the claimant appears at any such proceeding and actively and meaningfully participates through an attorney, the arbitrator may require that a reasonable fee for the claimant's attorney be paid by the employer or insurer determined by the arbitrator to be the party responsible for paying the claim."

The issue is whether claimant's participation through her attorney was active and meaningful. The arbitrator concluded:

> "[O]n balance, the participation by claimant and her counsel was sufficiently active and meaningful with respect to the responsibility issue to warrant an assessed attorney fee, for three reasons.
>
> "First, [not related to the .307 hearing].
>
> "Second, claimant, through [the attorney], filed and offered a number of exhibits relating to the responsibility issue. Similarly, claimant called herself as the only witness in the hearing. [The attorney] conducted relatively extensive direct and redirect examination of her on issues that were pertinent to which insurer was responsible. * * *

114 Or App 347> "Third, although claimant did not clearly and firmly take a position on which insurer should ultimately be held responsible, [the attorney] presented helpful argument on alternative analyses that arguably applied to deciding the responsibility issue. Given the complex and relatively fluid state of responsibility law at the time of the hearing, [the attorney's] argument meaningfully assisted the resolution of the responsibility issue. * * *"

The Board reversed the arbitrator and denied claimant attorney fees.

The legislature intended ORS 656.307(5) to be applied restrictively to allow attorney fees only when a claimant has a material, substantial interest in deciding who is the responsible insurer or employer, that is, if the claimant's benefits can be affected by the outcome of the responsibility hearing.[1] *See* Minutes, House Committee on Labor, March 25, 1987, pp 3-5. Unless a claimant has a material, substantial interest in deciding who is the responsible party and takes a position advocating that interest, participation by the claimant's attorney, even if helpful to the arbitrator, would be meaningless to the claimant. Because claimant did not advocate that a particular employer is the responsible party, his participation was not "meaningful," and the arbitrator erred in finding that it was.

Remanded for reinstatement of attorney fees award for services rendered before issuance of order designating paying agent; otherwise affirmed.

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[1] The term "actively and meaningfully participates" was added to the bill on June 8, 1987, after it reached the Senate Committee on Labor. There is no explanation of why it was added. *See* Minutes, Senate Committee on Labor, June 9, 1987.

Cite as 114 Or App 356 (1992) July 22, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON

EBI COMPANIES, Petitioner,
v.
DEPARTMENT OF INSURANCE AND FINANCE, Respondent.
(91-002; CA A71689)

Judicial Review from Department of Insurance and Finance.
Argued and submitted April 22, 1992.
Jerald P. Keene, Portland, argued the cause for petitioner. With him on the brief was Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C., Portland.
David L. Runner, Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.
Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.
EDMONDS, J.
Reversed and remanded with instructions to allow reimbursement.
Warren, P.J., dissenting.

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114 Or App 358> This case is a sequel to *Independent Paper Stock v. Wincer*, 100 Or App 625, 788 P2d 466, *rev den* 310 Or 195 (1990). EBI seeks review of an order of the Department of Insurance and Finance (DIF) that denied its request for reimbursement of permanent total disability benefits that it had paid pursuant to an order of the Workers' Compensation Board. We reverse.

Although claimant had exhausted his rights to request further benefits, the Board ordered EBI to reopen the claim in 1988 pursuant to ORS 656.278(1).[1] EBI protested that the Board no longer had authority to award permanent disability after the amendment of ORS 656.278, which became effective January 1, 1988. The Board disagreed. EBI paid the award and sought judicial review. We reversed, holding, in *Independent Paper Stock v. Wincer, supra*, that the Board lacked own motion authority to make a permanent disability award. Before our decision was published, EBI submitted a request for

reimbursement from the Reopened Claims Reserve (Reserve). After the decision was published, DIF denied the request on the basis that it had no authority to reimburse benefits paid as permanent disability compensation. It reasoned that, because the Board's award of permanent disability was not authorized, reimbursement from the Reserve was not authorized.

The issue is whether the legislature intended to allow reimbursement under ORS 656.625(1) when the Board has erroneously awarded benefits under ORS 656.278. The <114 Or App 358/359> starting point is the language of the statute. ORS 656.625(1) provides:

> "The director shall establish a Reopened Claims Reserve within the Insurance and Finance Fund, for the purpose of reimbursing the additional amounts of compensation payable to injured workers that results from any award made by the board pursuant to ORS 656.278 after January 1, 1988."

We need not resort to rules of statutory construction or to legislative history if the language of the statute itself expresses the intent of the legislature. *Whipple v. Howser*, 291 Or 475, 481, 632 P2d 782 (1981). The Reserve was established to reimburse 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." (Emphasis supplied.) EBI paid claimant's benefits on the basis of an award made "pursuant to ORS 656.278." Although the award resulted from an erroneous exercise of the Board's authority, it still was an award "pursuant" to that statute. *See SAIF v. Roles*, 111 Or App 597, 601-02, 826 P2d 1039 (1992).

The dissent would rewrite ORS 656.625(1) to say that the legislature intended that the award must be "authorized" by ORS 656.278 and, therefore, EBI is not entitled to reimbursement, even though it has paid an award that the claimant is not obligated to repay by reason of ORS 656.313(2). Our mandate is "not to insert what has been omitted." ORS 174.010. If the legislature had intended that result, it would have said so.[2] Moreover, the dissent's and DIF's interpretation put EBI in a dilemma, because it could not have refused to pay the award without subjecting itself to <114 Or App 359/360> greater potential liability. EBI raised the appropriate argument before the Board, and it was rejected. Even though EBI sought review, it was obligated under ORS 656.313(1) (*since amended* by Or Laws 1990, ch 2, 23)3 to pay the award or risk the imposition of a penalty and attorney fees. *See* ORS 656.382(1); ORS 656.262(10). Finally, it is unlikely that the legislature would have intended to preclude an insurer that complied with the Board's order from obtaining reimbursement because the Board, not the insurer,

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[1] ORS 656.278(1) provides:

> "Except as provided in subsection (5) of this section, the power and jurisdiction of the board shall be continuing, and it may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified in those cases in which:
>
> "(a) There is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, the board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the board; or
>
> "(b) The date of injury is earlier than January 1, 1966. In such cases, in addition to the payment of temporary disability compensation, the board may authorize payment of medical benefits."

[2] The language of what would become ORS 656.625 was originally introduced as part of 1987 House Bill 2103. House Bill 2900 replaced House Bill 2103 but included many of the same provisions. Early drafts of what would become ORS 656.625(1) said:

> "The director shall establish a Reopened Claims Reserve within the Administrative Fund, for the purpose of paying the additional amounts of compensation payable to injured workers that *results from exercise of authority by the board pursuant to ORS 656.278*." (Emphasis supplied.)

Exhibit F, House Committee on Labor, April 29, 1987; Exhibit A, House Committee on Labor, May 1, 1987; Exhibit F, House Committee on Labor, May 6, 1987. It is not clear from the legislative history why or when the language was changed.

[3] ORS 656.313(1) provided:

> "Filing by an employer or the insurer of a request for review or court appeal shall not stay payment of compensation to a claimant."

erred. We conclude that, because the award was paid "pursuant to ORS 656.278," EBI is entitled to reimbursement.

Reversed and remanded with instructions to allow reimbursement.

WARREN, P.J., dissenting.

ORS 656.625(1) permits an insurer to recover reimbursement for "the additional amounts of compensation payable to injured workers that results from any award made by the board *pursuant to* ORS 656.278." (Emphasis added.) Without citing any persuasive authority,[1] or providing any rationale, the majorty concludes that an award that results from an erroneous exercise of the Board's authority under ORS 656.278 is still an award issued "pursuant to" that statute. Because an action that is not authorized by a statute is not an action taken pursuant to that statute, I dissent.

Our role in construing a statute is to ascertain the intent of the legislature. ORS 174.020. We begin with the words of the statute. ORS 174.010; *Whipple v. Howser*, 291 Or 475, 479, 632 P2d 782 (1981). However, when those words do not provide sufficient insight into the legislature's intent, they are ambiguous, and we must look beyond those words to divine that intent. *Mattiza v. Foster*, 311 Or 1, 4, 803 P2d 723 (1991). No matter how apparent the meaning of a statute may be, if we cannot tell whether the legislature intended a statute <114 Or App 360/361> to apply in a particular context, we must resort to extrinsic aids to construction.

The words "pursuant to," as used in ORS 656.625, do not unambiguously express whether the legislature intended ORS 656.625 to apply when the Board erroneously exercises its authority under ORS 656.278 or, rather, only when the Board properly exercises its authority under that statute. Accordingly, we may resort to extrinsic aids to construction to divine the meaning of those terms.

The legislative history reveals that, when first introduced, the drafts of what became ORS 656.625(1) provided:

> "The director shall establish a Reopened Claims Reserve * * * for the purpose of paying the additional amounts of compensation payable to injured workers that results from *exercise of authority* by the board pursuant to ORS 656.278." (Emphasis supplied.) Exhibit F, House Committee on Labor, April 29, 1987; Exhibit A, House Committee on Labor, May 1, 1987; Exhibit F, House Committee on Labor, May 6, 1987.

ORS 656.625(1) now provides:

> "The director shall establish a Reopened Claims Reserve * * * for the purpose of reimbursing 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."

It is unclear from the legislative history why or when the language "exercise of authority" changed to "any award made." Presumably, had the legislature intended that change to alter the substance of the statute, it would have discussed the change, either in committee or on the floor. No discussions were recorded. Therefore, we should infer that the change was intended to be a technical refinement. So construed, the changed language merely reflects the truism that, pursuant to ORS 656.278, the only "exercise of authority" by the Board that can result in a reimbursable expenditure is the making of an award. The change was not intended to dispense with the requirement that the Board validly exercise its authority before an insurer can seek reimbursement for an award.

I dissent.

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[1] The majority cites SAIF v. Roles, 111 Or App 597, 601-02, 826 P2d 1039 (1992). That case says that the Board does not lack subject matter jurisdiction simply because an action is unauthorized. It does not say that authorized and "pursuant to" are synonymous.

Cite as 114 Or App 453 (1992) August 5, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Nicolasa Martinez, Claimant.

NICOLASA **MARTINEZ**, Petitioner,
v.
DALLAS NURSING HOME, Respondent.
(WCB 90-12293; CA A70827)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 17, 1992.
Brad G. Garber, Salem, argued the cause for petitioner. With him on the brief was Michael B. Dye, Salem.
Darren L. Otto, Portland, argued the cause for respondent. With him on the brief was Scheminske & Lyons, Portland.
Before Richardson, Presiding Judge, and Deits and Durham, Judges.
RICHARDSON, P.J.
Affirmed.

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114 Or App 455> Claimant petitions for review of a Workers' Compensation Board order that denied her an attorney fee paid by employer under ORS 656.382(1). She argues that the Board incorrectly interpreted ORS 656.262(10) to preclude a separate award of attorney fees. We affirm.

The parties accept the findings of the Board:

> "On April 4, 1990, the Board affirmed and adopted a Referee's December 5, 1988 order that set aside the employer's denial of claimant's medical services claim for her low back condition. This claim pertained to chiropractic treatments provided by Dr. Romanick. The Board's order was not appealed within 30 days from its issuance.
>
> "The employer did not pay the disputed chiropractic bills within 60 days of the Board's order. On June 11, 1990, the Board received claimant's hearing request, which raised the issues of medical services, penalties and attorney fees. The employer paid the medical bills on July 6, 1990.
>
> "Prior to the scheduled hearing, the parties entered into an 'Interim Partial Stipulation and Order of Dismissal.' Pursuant to the stipulation, the employer agreed that $1,289.91 in medical bills were untimely paid. Consequently, the employer agreed to pay a penalty equal to 25 percent of that amount, i.e., $322.47.
>
> "In accordance with the stipulation, claimant agreed to accept the aforementioned penalty on the condition that she could seek entitlement to a carrier-paid attorney fee under ORS 656.382(1). In the event that the Referee did not grant her such an attorney fee, claimant agreed that her attorney would receive one-half of her penalty, i.e., $161.24. Thereafter, the Referee approved the interim stipulation and accepted written arguments regarding claimant's entitlement to an attorney fee under ORS 656.382(1)."

The Board concluded that the 1990 amendments to ORS 656.262 preclude an award of attorney fees under ORS 656.382(1) in this case. The Board set forth its reasoning in its Conclusions of Law:

> "*Former* ORS 656.262(10) authorized the assessment of an attorney fee under ORS 656.382(1) if a carrier unreasonably refuses to pay compensation. However, the legislature amended ORS 656.262(10) during its 1990 Special Session. See Or Laws 1990 (Special Session), Ch. 2, 15. In place of <114 Or App 455/456> the language authorizing the assessment of an attorney fee under ORS 656.382(1), ORS 656.262(10)(a) [now] provides that, if the worker is represented by an attorney, the attorney shall receive one-

half the penalty 'in lieu of an attorney fee.' Accordingly, claimant's attorney is awarded one-half of the penalty assessed by the Referee's order, in lieu of an attorney fee.

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

We agree with the Board's reasoning. We have reviewed the legislative history of the amendment to ORS 656.262 and, although the record is sparse, it does support that interpretation.[1] The phrase "in lieu of an attorney fee" and the deletion of the reference to ORS 656.382 indicate a legislative intent to limit attorney fees in these circumstances to one-half the penalty awarded under ORS 656.262(10). Claimant was not entitled to an additional award of attorney fees under ORS 656.382(1).

Affirmed.

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[1] See Minutes, 1990 Joint Special Session, Committee on Workers' Compensation, May 4, 1990, pp 33-34.

Cite as 114 Or App 471 (1992) August 5, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Jesus H. Ferrer, Claimant.

GEORGIA-PACIFIC CORPORATION, Petitioner,
v.
JESUS H. **FERRER**, Respondent.
(90-16636; CA A71244)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 20, 1992.
Charles L. Lisle, McMinnville, argued the cause for petitioner. With him on the brief was Cummins, Brown, Goodman, Fish & Peterson, P.C., McMinnville.
Brent Wells, Eugene, argued the cause for respondent. With him on the brief were Jon C. Correll and Malagon, Moore & Johnson, Eugene.
Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.
ROSSMAN, J.
Affirmed.

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114 Or App 473 > In this workers' compensation case, petitioner, a self-insured employer, seeks review of an order of the Board affirming the referee's decision to overturn employer's denial of claimant's claim for compensation. We affirm.

On June 21, 1990, claimant filed a claim for an upper back strain arising out of his employment as a millworker. Claimant alleged that he first noticed the onset of symptoms on or about May 15, 1990, but he did not seek medical treatment until his back pain became intolerable. On June 25, 1990, he sought medical treatment from Dr. Brazer, who noted muscle spasms. Brazer allowed claimant to continue working with restrictions against lifting over 20 pounds and referred him to an orthopedist, Dr. Adams, who diagnosed an upper back and neck strain caused by his work. In July, claimant was seen by another orthopedist, Dr. Woolpert, who also diagnosed a cervical-thoracic strain, caused by

claimant's work. There were specific findings of tenderness along the spine. With the approval of Brazer and Adams, claimant was limited to light work with restrictions for several weeks.

On August 6, 1990, employer denied the claim for compensation, on the basis that there were insufficient *objective* medical findings of a compensable injury. The referee held that ORS 656.005(7)(a) does not require a specific "quantum" of objective findings and that claimant had established that his injury was compensable. The Board affirmed, citing only *Suzanne Robertson*, 43 Van Natta 1505 (1991), in which the Board upheld the compensability of the claimant's injury after examining the legislative history of ORS 656.005(7)(a) to determine the meaning of "objective findings." Employer petitions for review of that decision.

Employer argues that the Board erred as a matter of law in adopting the referee's decision that claimant had established a compensable injury supported by objective medical findings. ORS 656.005(7)(a) provides, in part:

> "A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, <114 Or App 473/474> *if it is established by medical evidence supported by objective findings* * * *." (Emphasis supplied.)

In addition, ORS 656.005(19) provides:

> "'*Objective findings*' in support of medical evidence include, but are not limited to, range of motion, atrophy, muscle strength, muscle spasm and diagnostic evidence substantiated by clinical findings." (Emphasis supplied.)

In *Suzanne Robertson, supra*, the Board discussed the legislative history of the statute, and section 19 in particular, concluding:

> "[T]he legislature did not intend to exclude those findings based on an injured worker's subjective complaints. Rather, we believe that the intent was to require a determination by a physician, based on examination of the injured worker, that an injured worker has a disability or need for medical services. *Such a finding* may be based on a physically verifiable impairment, but, as stated by the committee members, *may also be based on the physician's evaluation of the worker's description of the pain that she is experiencing.*" (Emphasis supplied.)

Employer concedes that ORS 656.005(19) is ambiguous "in that it is unclear whether or not 'objective findings' may be based on an injured worker's subjective complaints." It also agrees that the decision in *Suzanne Robertson* is a correct statement of legislative intent. However, it asserts that the Board erred, because "[t]he facts of this case present a perfect example of doctors prescribing treatment and disability based solely upon a worker's subjective representation of injury," and that, under the facts, the doctors' evaluation of claimant's complaints cannot be deemed "tantamount to 'diagnostic evidence substantiated by clinical findings,'" within the meaning of ORS 656.005(19).

The record shows that each physician's diagnosis was based both on claimant's subjective responses that he experienced pain at various locations on his body and on a physical examination of objective muscle responses. Brazer reported claimant's complaints of continuing tenderness along his spine over a one-month period, along with objective findings of muscle spasms. Woolpert reported that claimant had tenderness in response to palpation in the sub-occipital, paravertebral, trapezius and rhomboid areas. He also noted <114 Or App 474/475> that compression testing produced increased neck pain that was relieved with traction. Adams explained the results of his examination:

> "[T]he only objective findings that I could find was the fact that [claimant] was tender in multiple areas about the lower neck, upper back, shoulders, lower back and all along his spine. * * * *It is a relatively objective finding when the patient says he hurts when you touch him.*" (Emphasis supplied.)

In examining the facts in *Suzanne Robertson, supra,* the Board held:

> "[The doctor] stated that claimant had a pulling sensation while testing the range of motion of the lumbar spine and muscle tenderness on palpation. He did not report that claimant merely complained of a pulling sensation or tenderness. *He determined, evidently based on his physical exam, that she did, in fact, suffer from those conditions.*" 43 Van Natta at 1507. (Emphasis supplied.)

Similarly, on the basis of their objective evaluations of claimant's complaints of pain in specific areas of his back and his muscular responses during physical examinations, all three doctors in this case concluded that claimant suffers from a cervical dorsal strain. The Board did not err.

Affirmed.

Cite as 114 Or App 486 (1992) August 5, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Robert W. McDonald, Claimant.

ROBERT W. **McDONALD**, Petitioner,
v.
ROSEBURG FOREST PRODUCTS, Respondent.
(88-04585; CA A67378)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 17, 1992.
Karsten H. Rasmussen, Eugene, argued the cause for petitioner. With him on the brief was Rasmussen & Henry, Eugene.
Adam T. Stamper, Medford, argued the cause for respondent. With him on the brief was Cowling & Heysell, Medford.
Before Richardson, Presiding Judge, and Deits and Durham, Judges.
DEITS, J.
Affirmed.

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114 Or App 488> Claimant seeks review of an order of the Workers' Compensation Board (Board) denying his aggravation claim. We affirm.

Claimant suffered compensable injuries to his back in 1984, 1985 and 1987. The claims were closed by a determination order issued in February, 1988, and reopened in June, 1988, when claimant underwent surgery. He returned to work in December, 1988. On January 9, 1989, Dr. Hebert reported that claimant was experiencing a "flare-up" of his back condition. However, claimant continued to work. A determination order dated January 26, 1989, closed the reopened claim and awarded claimant 31 percent unscheduled permanent disability. After that, Hebert authorized claimant's release from work from February 15 through March 15, 1989, and filed an aggravation claim on claimant's behalf, which employer denied. Claimant underwent MRI scans on March 21 and 24, which revealed "no evidence of a new disc herniation." His surgeon, Dr. Smith, examined the test results and concurred in the finding of no significant change in claimant's condition.

Claimant sought review of the denial, and a hearing was held on March 28, 1989. The referee found that claimant had suffered an aggravation and ordered the claim reopened. The Board reversed the referee, concluding that claimant had not established a worsening of his condition since the date of the last arrangement of compensation, the January 26 determination order. ORS 656.273(1).[1] The Board also increased claimant's award of unscheduled permanent disability to 43 percent.

Claimant assigns error to the Board's denial of his aggravation claim. He argues that the Board's order is not supported by substantial evidence, because "[t]here is no **<114 Or App 488/489>** medical or other evidence which supports the Board's determination that [his] condition had not

worsened." He also contends that the Board's order should be remanded because, in view of the evidence of a worsening, it failed to explain its holding that he had not proven his aggravation claim.

We conclude that there is substantial evidence to support the Board's order. Although claimant's doctor, Hebert, did diagnose a "flare up" and a "material worsening" of claimant's 1984 condition in a report dated January 16, 1989, that report was issued *before* the last arrangement of compensation. The March 21 and March 24 MRI's, taken after the January 26 determination order, revealed "no evidence of a new disc herniation." The Board did not err in concluding that claimant failed to establish a worsening of his compensable condition as required by ORS 656.273(1).

The Board did explain its decision in view of the evidence in the record:

> "[T]he last arrangement of compensation was the January 26, 1989 Determination Order. Prior to that time, Dr. Herbert [sic] reported that claimant was not medically stationary and was experiencing a 'flare-up' of his condition. He further indicated that he had a material worsening of his condition as of his January 16, 1989 treatment. Although Dr. Herbert [*sic*] eventually released claimant from work following the Determination Order, we conclude that the release stemmed from claimant's condition prior to January 26, 1989. Inasmuch as claimant's condition was the same prior to January 26, 1989 as it was subsequent to that date, claimant has not established a worsened condition since January 26, 1989, his last arrangement of compensation. Accordingly, he has not proven a compensable aggravation. *See* ORS 656.273(1)."

The Board's upholding of the denial of claimant's aggravation claim is correct.

Affirmed.

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[1] 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."

Cite as 114 Or App 514 (1992) August 5, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Arliss C. Hughes, Claimant.

ARLISS C. **HUGHES**, Petitioner,
v.
SAIF CORPORATION and MOE'S RESTAURANT, Respondents.
(87-03398, 88-11189, 87-19163, 88-07600, 88-07601; CA A64863)

Judicial Review from Workers' Compensation Board.
Submitted on record and briefs July 16, 1992.
Karen M. Werner, Eugene, filed the brief for petitioner.
Charles S. Crookham, 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 Joseph, Chief Judge, and De Muniz, Judge.
PER CURIAM
Reversed and remanded for reconsideration of attorney fees.

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114 Or App 515> The Workers' Compensation Board held that claimant's attorney was not entitled to an insurer-paid attorney fee under *Jones v. OSCI*, 107 Or App 78, 810 P2d 1318 (1991). After that decision, the legislature amended ORS 656.386(1) to authorize an insurer-paid attorney fee when a claimant's attorney is instrumental in obtaining compensation without a hearing. Or Laws 1991, ch 312, 1. We

then withdrew our opinion in *Jones* and remanded to the Board for an award of attorney fees. 108 Or App 230, 814 P2d 558 (1991). Respondents concede that claimant's attorney may be entitled to a fee under that amendment and that the Board's order should be vacated and the case remanded for reconsideration. We accept the concession. *See Northcutt v. BJ's Ice Cream Parlor*, 113 Or App 748, ___ P2d ___ (1992); *Valencia v. Bailey Nurseries*, 113 Or App 74, 829 P2d 1056 (1992).

Reversed and remanded for reconsideration of attorney fees.

Cite as 114 Or App 543 (1992) August 5, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Earnest E. Lasley, Claimant.

EARNEST E. **LASLEY**, Petitioner,
v.
ONTARIO RENDERING and SAIF CORPORATION, Respondents.
(89-21542; CA A68972)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 30, 1991.
Clayton C. Patrick, Salem, argued the cause for petitioner. Douglas J. Rock, J. Robert Moon, Jr., and Coughlin, Leuenberger & Moon, P.C., Ontario, filed the brief for petitioner.
Steven R. Cotton, 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.
Affirmed.

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114 Or App 545> Claimant seeks review of an order of the Workers' Compensation Board reversing the referee's decision on review of an order of the Director of the Department of Insurance and Finance concerning claimant's eligibility for vocational assistance.

This is the first case in which we are asked to address the scope and standard for review of a decision of the Director pursuant to ORS 656.283(2) concerning vocational assistance. The Director determined that claimant was disqualified from vocational services under former OAR 436-120-045(7), which provided that the eligibility of a worker for benefits ends when "[t]he worker has failed, after written warning, to cooperate in the development of a return-to-work plan." The referee modified the Director's decision, concluding that the facts support only the conclusion that claimant was disqualified from receiving benefits under former OAR 436-120-045(10), which provided that the eligibility of a worker for vocational assistance ends when "[t]he worker's lack of suitable employment cannot be resolved by currently providing vocational assistance." Under those circumstances, presumably, claimant would be eligible for services later when they could be of assistance to him.

The Board concluded that the referee had erred and held that the Director had not abused his discretion in disqualifying claimant under former OAR 436-120-045(7), and reversed the referee. The Board also held that, having been disqualified under that section, claimant is ineligible for benefits in the future. On review, claimant contends that his entitlement to services would have been more appropriately terminated pursuant to OAR 436-120-045(10), and he argues that the Director abused his discretion in not terminating benefits pursuant to that subsection.

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.

114 Or App 546> "(2) If a worker is dissatisfied with an action of the insurer or self-

insured employer regarding vocational assistance, the worker must first apply to the director for administrative review of the matter before requesting a hearing on that matter. Such application must be made not later than the 60th day after the date the worker was notified of the action. The director shall complete the review within a reasonable time, unless the worker's dissatisfaction is otherwise resolved. The decision of the director may be modified only if it:

"(a) Violates a statute or rule;

"(b) Exceeds the statutory authority of the agency;

"(c) Was made upon unlawful procedure; or

"(d) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion."

The remainder of the section deals generally with the process for requesting a hearing on a claim, the assignment of the case by the Board to a referee, the making of a record and the hearing procedure.

OAR 436-120-210 is the administrative rule relating to vocational assistance disputes. It provides, in part:

"(1) Under ORS 656.283, a worker must first apply to the Director for administrative review of a vocational assistance matter before requesting a hearing on the matter. * * * An order of the Director under section (6) of this rule constitutes such a review.

"* * * * *

"(6) If a worker's dissatisfaction about a vocational assistance matter has not been resolved by a conference or otherwise, the Director will issue a written decision within a reasonable time. This decision will be the final order of the Director in the matter, as prescribed in ORS 656.283. Appeal may be made as provided in that statute, but shall not stay compliance with the order."

Under both the statute and the rule, if a worker is dissatisfied with the insurer's action concerning vocational assistance, he must seek administrative review by the Director before requesting a hearing. Neither the statute nor the administrative rule requires the Director to hold a hearing, to create a record or to make findings in support of his decision on a vocational assistance <114 Or App 546/547> matter. That is consistent with the legislature's apparent intention to encourage informal and expeditious resolution of vocational assistance disputes. *See SAIF v. Severson*, 105 Or App 67, 70, 803 P2d 1203 (1990), *mod* 109 Or App 136, 817 P2d 1352 (1991). Claimant sought review by the Director and, after an investigation by agency staff, the Director issued a written order concluding that claimant had failed, after several written warnings, to cooperate with his vocational consultant and is therefore disqualified pursuant to OAR 436-120-045(7) from receiving vocational assistance.

If a worker is dissatisfied with the Director's order, he may request a hearing, pursuant to ORS 656.283. A referee then reviews the Director's decision. The question is how the referee and, subsequently, the Board and this court determine whether the Director's decision is subject to modification for one of the reasons described in ORS 656.283(2). The statute does not tell us how the process is to be carried out.

Under ORS 656.283(2), the hearing to which a claimant is entitled must be for the purpose of determining the historical facts relevant to the dispute. That responsibility is unaffected by the scope of review limitations in subsections (a) through (d). On the basis of that record, the referee may make findings of ultimate fact to determine whether the Director's order is subject to modification for any of the specific reasons in ORS 656.283(2). On review, to determine whether the Director's order is subject to modification, the Board reviews the record made by the referee but may make findings of ultimate

fact different from those made by the referee. This court, however, reviews the Board's decision only for errors of law and substantial evidence. ORS 656.298; ORS 183.482.

Claimant contends that the Director abused his discretion in determining that SAIF had properly terminated vocational assistance pursuant to OAR 436-120-045(7), rather than subsection (10) of that rule, by failing to give more weight to reports that his psychological condition was not medically stationary. The Board said:

> "[W]e cannot conclude that the Director abused his discretion by finding that SAIF properly terminated claimant's <114 Or App 547/548> vocational assistance due to his failure, after written warning, to cooperate in the development of his return-to-work plan. The record supports the Director's conclusion that claimant was provided with written warnings that his eligibility would be terminated if he did not take steps to maintain contact and participate in the provided services. The record also supports the conclusion that claimant did not comply with the written warnings.
>
> "In reaching his conclusion, the Director arguably could have applied OAR 436-120-0[45](10) and determined whether termination of services was proper due to the fact that claimant's lack of suitable employment could not be resolved by currently providing vocational assistance. However, we do not find that it was an abuse of discretion for the Director to base his conclusion upon OAR 436-120-0[45](7). We are unconvinced that, even if claimant was not medically stationary at the time of termination of vocational services, his status precluded him from cooperating in the development of a return-to-work plan, as prescribed by that rule.
>
> "Moreover, even if the Director's authorization of termination properly could have been based upon more than one administrative rule (i.e., OAR 436-120-0[45](7) and OAR 436-120-0[45](10)), we cannot conclude that it was an abuse of discretion for the Director to place more reliance upon one of those rules in arriving at his conclusion."

The Board's determination that the Director did not abuse his discretion in disqualifying claimant under subsection (7) rather than subsection (10) is supported by the Board's findings and is not erroneous as a matter of law.

Affirmed.

Cite as 115 Or App 70 (1992) August 26, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Riley E. Lott, Jr., Claimant.

OREGON BOILER WORKS and EMPLOYERS INSURANCE OF WAUSAU, Petitioners,
v.
RILEY E. **LOTT**, JR., CNA INSURANCE COMPANY, COMBUSTION ENGINEERING, LIBERTY NORTHWEST INSURANCE CORPORATION, OREGON BOILER WORKS, CIGNA INSURANCE, BABCOCK & WILCOX, SAIF CORPORATION, ARROW INDUSTRIAL MAINTENANCE, EMPLOYERS INSURANCE OF WAUSAU and PACIFIC STEEL FABRICATORS,
Respondents.
(89-23291, 89-14700, 89-14699, 89-14698, 89-12184, 89-14697; CA A68691)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 18, 1991.

Larry D. Schucht, Portland, argued the cause for petitioners. With him on the brief were Kevin N. Keaney, and Stoel Rives Boley Jones & Grey, Portland.

David L. Johnstone, Portland, waived appearance for respondent Riley E. Lott, Jr.

Craig A. Staples, Portland, argued the cause for respondents CNA Insurance Company and Combustion Engineering. With him on the brief was Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C., Portland.

Jenny Ogawa, Salem, waived appearance for respondent Liberty Northwest Insurance Corporation.

No appearance for respondents Cigna Insurance and Babcock & Wilcox.

Michael O. Whitty, Special Assistant Attorney General, Salem, waived appearance for respondents SAIF Corporation and Arrow Industrial Maintenance.

Richard H. Rizk, Beaverton, argued the cause and filed the brief for respondents Employers Insurance of Wausau and Pacific Steel Fabricators.

Before Richardson, Presiding Judge, and Joseph, Chief Judge, and Deits, Judge.

DEITS, J.

Affirmed.

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115 Or App 73> Employer Oregon Boiler Works (OBW) seeks review of an order of the Workers' Compensation Board holding it responsible for claimant's occupational disease claim. We affirm.

Claimant was discharged from the Army in 1970. At that time, he had suffered some hearing loss. In 1974, he began working as a boilermaker. He was working for OBW in March, 1983, when he sought medical treatment for his hearing loss, which had worsened since 1970. Thereafter, he occasionally wore a hearing aid in his right ear. He did not then make a claim against OBW. He worked for Combustion Engineering (CE) in 1987, for Pacific Steel Fabricators (PSF) in 1988 and again for CE for five days in 1989. He did not lose any time from work as a result of his hearing loss.

In April, 1989, claimant filed a workers' compensation claim against the three employers. Each employer denied responsibility. Both the referee and the Board found that claimant's hearing loss has worsened since March, 1983, when he first sought medical treatment. The referee concluded that the last injurious exposure rule applies and that, because claimant's work exposure while working for his last employer, CE, *could* have caused his condition and there is no evidence that an earlier employment was the sole cause of the worsening, CE is responsible for claimant's condition.

The Board reversed the referee, holding that, once liability is initially fixed, responsibility does not shift to a subsequent employer unless it is proved that the work exposure at the subsequent employer actually caused a worsening of the underlying disease. The Board then concluded that

> "the medical evidence is not sufficient to show actual causation by claimant's employment with CE. The worsening could just as likely have resulted from the exposure claimant had [at] Oregon Boiler Works *after* March 1983. Therefore, we

conclude that responsibility remains with Wausau's insured, Oregon Boiler Works, the employer with whom liability was originally fixed." (Emphasis supplied.)

OBW argues that the Board erred in refusing to place responsibility on CE. It first contends that the Board should have disregarded the opinion of Dr. Lipman that claimant's <115 Or App 73/74> work at CE did not actually worsen his condition, because Lipman based that opinion on his erroneous belief that claimant wore earplugs while working at CE. Even assuming that Lipman was mistaken as to claimant's use of earplugs at CE, the evidence shows that that was only one of several factors on which he relied. He also considered the short duration of the employment--five days--and the low noise levels at the job site. The Board recognized that there were inconsistencies in Lipman's testimony but, nonetheless, concluded that "the medical evidence is not sufficient to show actual causation by claimant's employment with CE." The Board's findings are supported by substantial evidence.

OBW also argues that the "record shows that the post-1983 employers' work sites worsened claimant's hearing" and that, because the CE work was the last that "could have" contributed to the hearing loss, CE is responsible for the condition. We agree with the Board that, in order to shift responsibility from OBW to CE, it must be shown that the condition was *actually* worsened by the work exposure at CE.

Ordinarily, responsibility for an occupational disease is assigned to the claimant's employer at the time that the disease results in disability. However, when the worker is not disabled by the disease, the "triggering event" for assignment of responsibility is the time when the worker first seeks medical treatment for the condition. *Progress Quarries v. Vaandering*, 80 Or App 160, 163, 722 P2d 19 (1986). Claimant did not lose time from work. OBW was his employer when he first sought medical treatment for his hearing loss. Thus, it was initially responsible for the condition.

OBW does not dispute that it was initially responsible. It contends, however, that responsibility shifted from it to a subsequent employer, CE. To shift responsibility for an occupational disease claim to a later employer, the earlier employer must prove that the later employment conditions actually contributed to a worsening of the condition. *Boise Cascade v. Starbuck*, 296 Or 238, 243, 675 P2d 1044 (1984); *Bracke v. Baza'r*, 293 Or 239, 250, 646 P2d 1330 (1982), *mod* 294 Or 483, 658 P2d 1158 (1983); *Progress Quarries v. Vaandering, supra*, 80 Or App at 166 (1982). The Board concluded that the evidence does not show that the work <115 Or App 74/75> exposure at CE actually contributed to a worsening of claimant's condition. As we have already said, that finding is supported by substantial evidence.

Affirmed.

Cite as 115 Or App 127 (1992) September 9, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Lester M. Gibson, Claimant.

ROSEBURG FOREST PRODUCTS, Petitioner,
v.
LESTER M. **GIBSON**, Respondent.
(WCB 89-25661; CA A69292)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 27, 1992.
Adam T. Stamper, Medford, argued the cause for petitioner. With him on the brief was Cowling & Heysell, Medford.
Glen H. Downs, Portland, argued the cause for respondent. With him on the brief were J. Michael Casey and Doblie & Associates, Portland.
Before Richardson, Presiding Judge, and Deits and Durham, Judges.
RICHARDSON, P.J.
Affirmed.
Durham, J., concurring.

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115 Or App 129> Employer seeks review of an order of the Workers' Compensation Board that reversed its denial of temporary total disability benefits (TTD) to claimant. The parties agree that the issue is whether, at the time that claimant's aggravation occurred, he had withdrawn from the work force and was therefore not entitled to TTD.

The parties accept the findings of the referee that were adopted by the Board. Claimant sustained a compensable low back injury in April, 1988, at employer's mill. Despite persistent back and leg pain, he continued to work. On January 10, 1989, he went on strike with his union. The low back and leg symptoms became extremely acute and, on January 27, 1989, a neurosurgeon diagnosed a herniated disc related to his compensable injury. He had surgery on March 28, 1989. The strike ended in May, 1989, and claimant returned to work with employer. He sought, *inter alia*, TTD from January 27, 1989, until the end of the strike. Employer denied benefits because claimant had voluntarily withdrawn from the work force during the strike.

The Board held that claimant had not withdrawn from the work force, relying on its decision in *Ellis N. Phillips*, 43 Van Natta 231 (1991). On review, we reversed that decision. *Roseburg Forest Products v. Phillips*, 113 Or App 721, ___ P2d ___ (1992). Employer argues that the cases are identical and so the decision should be the same.

Although there are striking similarities in the two cases, there are material differences that dictate a different result. In *Phillips*, we recited the relevant inquiry from *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 778 P2d 497 (1989):

> "A claimant is deemed to be in the work force if:
>
> "a.The claimant is engaged in regular gainful employment; or
>
> "b.The claimant, although not employed at the time, is willing to work and is making reasonable efforts to obtain employment * * *; or
>
> "c.The claimant is willing to work, although not employed at the time and not making reasonable efforts to obtain employment because of a work-related injury, where <115 Or App 129/130> such efforts would be futile." 308 Or at 258. (Citations omitted.)

In *Phillips*, the claimant was on strike, not willing to work for the employer and was not seeking any other work. We concluded that, under the criteria of *Dawkins*, he had voluntarily left the work force during the strike.

Claimant testified that his wife was disabled and he needed to work and that, in the past, he had always sought other employment when there was a work stoppage. He would have gone to work someplace else during the strike if he had been able to work. The Board found, "If not for his back and leg symptoms [claimant] would have worked elsewhere during the strike." Unlike the claimant in *Phillips*, claimant had not withdrawn from the work force when the aggravation of his injury occurred. He is not foreclosed from receiving TTD.

Affirmed.

DURHAM, J., concurring.

I concur with the court's decision. However, my concurrence should not be construed to imply that I agree with the holding in *Roseburg Forest Products v. Phillips*, 113 Or App 721, ___ P2d ___ (1992).

Cite as 115 Or App 154 (1992) September 9, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Ronald D. Robinson, Claimant.

AETNA CASUALTY COMPANY and THE BOEING COMPANY, Petitioners,
v.
RONALD D. **ROBINSON**, Respondent.
(89-13506; CA A69912)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 16, 1991.
Jeremy L. Fellows, Portland, argued the cause for petitioners. With him on the brief was Scheminske & Lyons, Portland.
Anthony A. Allen, Salem, argued the cause for respondent. On the brief were Jean Fisher LeDoux and Gatti, Gatti, Maier, et al, Salem.
Before Richardson, Presiding Judge, and Deits and Durham, Judges.
DEITS, J.
Affirmed.

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115 Or App 156> Employer seeks review of an order of the Workers' Compensation Board holding that claimant must only prove that his preexisting compensable injury was a material, rather than a major, contributing cause of his mental disorder and concluding that claimant's mental disorder was compensable. We affirm.

Claimant was a machinist for employer. In November, 1985, he suffered a compensable back injury when he slipped on ice in the company parking lot. He filed an aggravation claim for his back in April, 1988, which employer denied in February, 1989. In November, 1988, claimant also developed stomach problems and sleeplessness. He was depressed about being off work, financial and marital problems, as well as back pain. His chiropractor referred him to Colistro, Worthington and Associates for psychological evaluation and treatment. He was evaluated by Tinker, an unlicensed psychology resident, who diagnosed depression and authorized time loss as of May 23, 1989.

In July, 1989, employer denied compensability for "mental disorder including all disability, symptoms and treatment in any way related thereto." Claimant requested a hearing. The referee found that claimant's injury was a material contributing cause of his psychological condition. He was awarded compensation for his psychological condition. Employer appealed, and the Board affirmed.[1]

Employer first assigns error to the Board's conclusion that claimant was only required to prove

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[1] The Board's order also upheld employer's denial of claimant's aggravation claim for his back. That portion of the order is not under review.

that his mental disorder was caused in material part by a preexisting compensable injury. It contends that claimant should have been required to meet the major contributing cause standard for an occupational disease under ORS 656.802(2). We have held, however, that ORS 656.802 is not applicable when a claimant seeks to recover benefits for a mental disorder that is a consequence of a compensable injury, but does not seek to establish the independent compensability of the disorder. *Boeing Co. v. Viltrakis*, 112 Or App 396, 398, 829 P2d 738 (1992). We conclude that claimant is seeking compensation of <115 Or App 156/157> a mental condition that is a consequence of his compensable injury. Accordingly, under the statutes in effect at the time of the hearing, he was only required to prove that his injury was a material contributing cause of his psychological condition.2 The Board applied the correct standard.

Employer also argues that, because claimant's mental condition developed gradually over a long period, the claim must be treated as an occupational disease claim. However, whether a mental condition develops gradually or suddenly is not necessarily determinative of whether the claim is for an occupational disease. Regardless of whether the onset is gradual or sudden, a mental condition that results directly from work is treated as an independent claim governed by ORS 656.802 and a mental condition that results from a compensable injury is treated as a claim for the consequences of an injury. *See Atlas Cylinder v. Epstein*, 114 Or App 117, 120, ___ P2d ___ (1992); *SAIF v. Hukari*, 113 Or App 475, ___ P2d ___ (1992). Even though the onset of the condition may have been gradual, the claim here was for a mental condition that is the consequence of an injury.

Employer also contends that this case must be analyzed under ORS 656.802(2), because claimant indicated that it was an occupational disease claim in his request for a hearing. However, that did not preclude the parties from presenting evidence of an injury, nor did it prevent the referee from considering the claim as an injury. OAR 438-06-031.

Employer next contends that there is not substantial evidence to support the Board's conclusion that his mental disorder was caused, even in material part, by his back injury. Although the Board found that over 50 percent of claimant's stress was caused by marital and financial difficulties, it found that it was also caused by being off work, his "uncertainty regarding his vocational future, and pain from his compensable injury." It also found that the sleeplessness was caused in part by back pain.

We conclude that there was substantial evidence to support the Board's finding. The psychologist who evaluated <115 Or App 157/158> claimant concluded that his condition is the direct result of his injury. Although employer's psychiatrist did not agree that claimant's mental condition is associated with his work, he did indicate that claimant was suffering depression associated with the financial ramifications of unemployment. There was also evidence in the reports of the chiropractor who was treating him that claimant's injury contributed to his depression.

Employer also assigns error to the denial of its motion to exclude from evidence the reports of Tinker, the unlicensed psychology resident. Employer objected to the admission of the reports on the ground that he was not licensed as a psychologist. The Board held:

> "Although a practitioner must be licensed in order to provide treatment under Chapter 656, *see* ORS 656.005(12); OAR 436-10-050, there is no requirement that a practitioner be licensed in order to provide an expert opinion. In fact, the Oregon Evidence Code describes an expert witness as one 'qualified as an expert by knowledge, skill, experience, training or education.' *See* OEC 702."

We agree that the fact that Tinker was not licensed does not make his opinion inadmissible. There is no requirement in the statutes or rules that mandates that a psychologist be licensed in order to give an opinion on a claimant's mental condition. His qualifications affect the weight to be given to the opinion rather than its admissibility. As the Board found, he worked under the supervision of Colistro. Although Colistro never saw claimant, the intern consulted with him and Colistro approved his reports. The referee's opinion acknowledges that Tinker was unlicensed, but treats the report as credible,

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[2] ORS 656.005(7)(a)(A) has been amended and now provides:

"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.

because he has three degrees in psychology and a long history of working in the mental health field, had consulted with his supervisor in the course of evaluating claimant, "claimant's condition is [not] so subtle or complex that it is beyond the ken of someone not yet licensed." The Board did not err in denying employer's motion to exclude the report.

Affirmed.

Cite as 115 Or App 159 (1992) September 9, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Betty J. Smith-Sanders, Claimant.

MEIER & FRANK CO. and MAY DEPARTMENT STORES COMPANY, Petitioners,
v.
BETTY J. **SMITH-SANDERS**, Respondent.
(89-18180; CA A69500)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 27, 1992.
Jerald P. Keene, Portland, argued the cause for petitioners. With him on the brief was Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C., Portland.
Glen H. Downs, Portland, argued the cause for respondent. With him on the brief were J. Michael Casey and Doblie & Associates, Portland.
Before Richardson, Presiding Judge, and Deits and Durham, Judges.
DEITS, J.
Reversed on penalties and attorney fees; otherwise affirmed.

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115 Or App 161> Employer seeks review of an order by the Workers' Compensation Board holding it responsible for medical expenses associated with claimant's non-compensable injury and assessing penalties and attorney fees. We reverse on the penalties and attorney fees. Otherwise, we affirm.

The Board accepted the referee's findings. Claimant suffered a compensable back injury in June, 1988. She had returned to her job by June, 1989, working part-time, when she allegedly injured her right knee, requiring surgery. Claimant sought authorization from employer for the surgery in July, 1989. Employer gave oral authorization to both claimant and her surgeon's office, and the surgery was performed on August 4. On December 12, 1989, employer denied compensability of the right knee condition and the surgery. The Board agreed with the referee's conclusion that the injury itself was not compensable. It also affirmed the referee's holding that employer was liable for the costs of the surgery but for different reasons:

> "We agree with the Referee that the underlying knee condition is not compensable. The Referee found the knee surgery compensable as diagnostic surgery because the employer had authorized the surgery. The Referee was apparently applying estoppel to the employer. We do not agree that the surgery is compensable as diagonstic [sic] surgery, but we agree that the employer is estopped from denying the surgery."

Employer contends that, because it never accepted the claim in writing and did not authorize the surgery, the Board's holding that it was estopped from denying responsibility for medical expenses associated with the surgery was in error.

We first conclude that there is substantial evidence in the record to support the Board's finding that employer orally authorized the surgery.[1] Claimant testified that she spoke with a person named

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[1] Employer argues that the Board did not clearly find that it authorized the surgery. However, the Board said in its findings: "The employer informed both claimant and her surgeon that it was authorizing the surgery."

"Linda Ross," representing <115 Or App 161/162> employer, who authorized the surgery. Also, records at Portland Orthopedic Clinic contain a file note stating:

> "LINDA ROSS AT MAY COMPANY AUTHORIZED ARTHROSCOPY WITH MENISCECTOMY OF THE RIGHT KNEE ON 07-25-89, FOR BETTY SMITH-SANDERS."

Employer argues that, even if it did authorize the surgery, the Board erred in holding it responsible for expenses associated with the surgery. It points out that, under the Board's rules, an acceptance must be in writing. *See* ORS 656.262(6). Employer asserts that it did not authorize the surgery in writing and, in fact, issued a written denial in December. It argues that, because the statutes and rules provide the exclusive procedural scheme governing workers' compensation and because there is nothing in the statutes or rules allowing the Board to rely on an estoppel theory to hold an employer responsible for a claim, it cannot be held responsible for the surgery.

Employer is correct that, under the Board's rules, acceptance of a claim must be in writing. However, we do not agree that equitable estoppel can never be used to require the payment of benefits in a situation where the claim was not accepted in writing. Employer relies on *Stovall v. Sally Salmon Seafood*, 306 Or 25, 757 P2d 410 (1988), to support its argument that equitable estoppel is never available in workers' compensation cases. However, the holding in *Stovall* was more limited than employer asserts. There, the employer sought to *defeat* a claim by arguing that the claimant was estopped from making a claim because of misrepresentations on her employment application. The Supreme Court held that the doctrine of equitable estoppel could not be used to defeat a claim under those circumstances. The court reasoned that Oregon's workers' compensation scheme is to be construed liberally in favor of the worker:

> "We conclude that public policy as expressed by the legislature weighs in favor of not defeating a claim for benefits by application of a doctrine not endorsed by the legislature. If false representations by a worker to obtain employment are to defeat a claim for benefits under the doctrine of equitable estoppel, we leave it to the legislature so to provide." 306 Or at 39.

115 Or App 163> The rationale of *Stovall* does not compel the conclusion that estoppel may not be applied in some circumstances to compel payment of benefits.

Employer argues, alternatively, that, even if equitable estoppel is available in workers' compensation cases, it was misapplied here. In *Stovall*, the court explained:

> "'This doctrine of equitable estoppel or estoppel in pais is that a person may be precluded by his act or conduct, or silence when it was his duty to speak, *from asserting a right* which he otherwise would have had.' (Emphasis added.)' *Marshall v. Wilson*, 175 Or 506, 518, 154 P2d 547 (1944). 'The doctrine of estoppel is only intended to protect those who materially change their position in reliance upon another's acts or representations.' *Bash v. Fir Grove Cemeteries, Co.*, 282 Or 677, 687, 581 P2d 75 (1978)." 306 Or at 34. (Footnote omitted.)

Here, employer's act of telling claimant and her doctor to proceed with the surgery caused claimant to change her position in reliance on employer's conduct. In view of the goal of construing the workers' compensation act liberally in favor of the worker, we hold that the Board did not err in applying equitable estoppel in these circumstances to require employer to pay claimant's expenses of surgery.[2]

Employer also assigns as error the Board's award of penalties and attorney fees. An unreasonable delay or refusal to accept or deny a claim or pay compensation may result in penalties and attorney fees. ORS 656.262(10).[3] Employer contends that it acted in a timely manner in denying the surgery and that its denial was reasonable. The Board determined that employer acted unreasonably when it first authorized claimant's surgery, then denied payment.

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[2] The Board did not hold that employer was estopped from denying the compensability of claimant's knee condition.

115 Or App 164> However, medical expenses are not considered "compensation" pending acceptance or denial of a claim. ORS 656.262(6). Therefore, an employer's failure to pay or delay in paying medical benefits before it has accepted or denied a condition cannot support an award of penalties. *Eastmoreland Hospital v. Reeves*, 94 Or App 698, 702, 767 P2d 97 (1989). Claimant's condition had not been properly accepted or denied at the time of surgery; therefore, her surgery expenses were not compensation under 656.262(10). The Board improperly assessed a penalty on that basis. Furthermore, because medical expenses are not compensation, the Board also was precluded from awarding claimant attorney fees under ORS 656.382(1), which requires that the employer unreasonably resist the payment of compensation.[4]

Reversed on penalties and attorney fees; otherwise affirmed.

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[3] At the relevant time, ORS 656.262(10) provided:

"If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

The statute has since been amended. Or Laws 1990, ch 2, 15.

[4] ORS 656.382(1) provides:

"If an insurer or self-insured employer refuses to pay compensation due under an order of a referee, board of 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."

Cite as 115 Or App 165 (1992) September 9, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Petition of

MARCOTT TIMBER & TRUCKING, INC., Petitioner,
v.
The filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE**, Respondent below, and LIBERTY NORTHWEST INSURANCE CORPORATION and DEPARTMENT OF INSURANCE AND FINANCE, Respondents.
(88-11-004; CA A69141)

Judicial Review from Department of Insurance and Finance.

Argued and submitted January 27, 1992.

Daniel W. Goff, Eugene, argued the cause for petitioner. With him on the brief was Daniel W. Goff, P.C., Eugene.

Thomas H. Johnson, Portland, argued the cause and filed the brief for respondent Liberty Northwest Insurance Corporation.

David L. Runner, Assistant Attorney General, Salem, waived appearance for respondent Department of Insurance and Finance.

Before Richardson, Presiding Judge, and Deits and Durham, Judges.

DEITS, J.

Affirmed.

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115 Or App 167> Employer seeks review of an order of the Department of Insurance and Finance (DIF) dismissing its appeal of a workers' compensation premium audit for lack of jurisdiction. We affirm.

In January, 1988, Liberty Northwest Insurance Corporation (Liberty), employer's insurer, performed an audit of employer's workers' compensation premiums for the fiscal year October 1, 1986, to September 30, 1987. It determined that employer had failed to report "bonus pay" as part of its

subject payroll for the period and, because of that, it assessed employer an additional $25,000 in premiums. On February 25, 1988, Liberty mailed employer a copy of the resulting billing entitled "Audit Invoice." The billing requested payment of $25,000 by March 16, 1988. Employer disputed the additional assessment and attempted to convince Liberty that it was in error. Liberty and employer continued to discuss the matter, and employer provided Liberty with additional documentation. Liberty was not persuaded that the audit was in error and, on September 15, 1988, it sent a letter to employer stating that the "bonus pay" was part of the subject payroll and, if employer wished to appeal the audit, it had 60 days to do so from the date of the letter. Employer appealed to DIF on November 8, 1988.

On October 31, 1990, a hearing was held to determine whether DIF had jurisdiction to hear the appeal. DIF issued an order on January 31, 1991, dismissing the appeal for lack of jurisdiction. In the order, it found that employer had received its final premium audit billing on approximately February 25, 1988, but did not appeal until November 8, 1988.

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.*" (Emphasis supplied.)

Employer argues that its appeal was filed within the required 60 days, because it did not have a "final premium audit billing" until it received the September, 1988, letter.[1] <115 Or App 167/168> However, ORS 737.505(4) provides that the appeal time runs from "receipt of the billing." Employer received the billing in February. The fact that it engaged in continuing discussions with Liberty about the audit does not change that fact.

Petitioner also argues that the February billing was not a final premium audit billing, because it did not include language advising employer of its appeal rights as required by OAR 836-43-110(2). However, in *Kilham Stationery v. National Council on Comp. Ins.*, 109 Or App 545, 551, 820 P2d 842 (1991), we held that an insurer's failure to provide the required notice of appeal rights does not extend the 60-day time limit for filing an appeal.

Because the 60-day time limit is jurisdictional, *Pease v. National Council on Comp. Ins.*, 113 Or App 26, 830 P2d 605 (1992), DIF properly dismissed employer's appeal.

Affirmed.

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[1] Although it is not applicable to this case, OAR 836-43-170(7), effective June 1, 1990, establishes what is to be considered the "final premium audit billing:"

> "Subject to the exception provided in section (8) of this rule, for purposes of ORS 737.505, OAR 836-43-110 and this rule, the final premium audit billing of an employer is the first document issued by the insurer to the employer after its audit of the employer that:
>
> "(a) Contains the results of the audit; and
>
> "(b) States the amount of the difference between the estimated standard premium reported by the employer for the entire policy period and the final standard premium calculated after the policy period is over as determined pursuant to the audit."

OAR 836-43-170(8) provides:

> "If the insurer after an audit of an employer issues both a statement of the employer's account and a letter to the employer that explains the audit and states the amount of the difference:
>
> "(a) The insurer may provide the notice required in OAR 836-43-110 either in the statement of account or in the letter.
>
> "(b) Whichever document contains the required notice is the final premium audit billing for purposes of the 60-day period within which the Director must receive the request for a hearing. If the statement of account and the letter both contain the notice, the 60 day period begins upon receipt by the employer of the later-received document."

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