

**VAN NATTA'S
WORKERS' COMPENSATION REPORTER**

VOLUME 44

(Pages 2055-END)

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 precedential value.

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CITE AS

44 Van Natta ____ (1992)

In the Matter of the Compensation of
KEITH A. SHROCK, Claimant
WCB Case No. 91-11597
ORDER ON REVIEW
Philip Schuster II, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of Referee Peterson's order that increased claimant's scheduled permanent disability from 33 percent (15.84 degrees) loss of use or function of the right thumb, as awarded by the Order on Reconsideration, to 14 percent (26.88 degrees) loss of use or function of the right arm. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee increased claimant's total scheduled permanent disability award from 33 percent of the right thumb to 14 percent of the right arm. In making such a determination, the Referee included a value for loss of grip strength for the right hand. Noting that claimant is right-handed with grip strength in the right hand at 93 pounds and 98 pounds in the left hand, the Referee "assume[d] that his grip strength had to be at least equal to, if not greater than, the 98 pounds which now registers on the left." The Referee therefore calculated that claimant retains 90.5 percent grip strength on the right, and awarded an additional impairment value of 5 percent of the right forearm.

SAIF contends that claimant failed to establish by medical evidence that he has ratable diminished grip strength. We agree.

We rate claimant's scheduled permanent disability pursuant to WCD Admin. Order 6-1988, effective January 1, 1991. Under those standards, loss of grip strength is ratable provided the loss is attributable to nerve damage, atrophy or other anatomical changes due to the compensable condition. See former OAR 436-35-110(3)(a) and (d); Sandie K. Driver, 44 Van Natta 416 (1992); Martha L. Brunner, 42 Van Natta 2587 (1990). Decreased grip strength caused by loss of range of motion in the joints of the fingers receives no rating beyond that given for the loss of range of motion itself. Former OAR 436-35-110(3)(c).

In this case, the Referee rated claimant's grip strength loss under former OAR 436-35-110(3)(d). On review, claimant contends that the Referee properly applied the standards. He asserts that he did not experience decreased grip strength due to loss of motion, but rather due to either atrophy or other anatomical changes caused by the surgical procedure to repair the fractured thumb. The medical record does not support this contention.

First, Dr. Nolan, claimant's treating orthopedic surgeon (the only physician to examine claimant for the compensable injury), does not indicate that claimant has any loss of grip strength. The only "ratable loss" he reported to both SAIF and claimant's attorney was loss of range of motion. We decline to find a loss of grip strength based upon assumptions related to claimant's right hand dominance. See Martha L. Brunner, supra. Moreover, the record is devoid of any medical opinion which establishes that claimant's loss of grip strength, if any, is due to nerve damage, atrophy, or other anatomical changes as opposed to claimant's documented lost range of motion.

It is claimant's responsibility, under ORS 656.266, to establish the extent and nature of any permanent disability. Based on lack of evidence in the record, we conclude that claimant has not proven entitlement to a value for decreased grip strength under the standards. With the elimination of the grip strength award, claimant's impairment consists of right thumb range of motion losses. These values entitle claimant to a permanent disability award of 33 percent of the right thumb (15.84 degrees). Consequently, we reverse the Referee's award and reinstate the Order on Reconsideration.

ORDER

The Referee's order dated February 11, 1991 is reversed. The award of an out-of-compensation fee to claimant's counsel is reversed. The Order on Reconsideration is reinstated and affirmed.

September 30, 1992

Cite as 44 Van Natta 2056 (1992)

In the Matter of the Compensation of
SANDRA K. CORBETT, Claimant
WCB Case No. 91-15669
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Bonnie V. Laux (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of that portion of Referee Daughtry's order that increased claimant's scheduled permanent disability award from 4 percent (6 degrees), as previously awarded by an Order on Reconsideration, to 23 percent (34.5 degrees) loss of use or function of her right forearm. On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of his finding that claimant has 23 percent loss of use or function of her right forearm.

CONCLUSIONS OF LAW AND OPINION

On review, SAIF contests only that portion of the Referee's order that awarded claimant an impairment value for lost grip strength. SAIF first contends that only the findings of the medical arbiter may be used in rating claimant's impairment. Alternatively, SAIF argues that even the findings of claimant's treating physician do not support an award for loss of grip strength, as the loss has not been attributed to nerve damage, atrophy or anatomical change.

We have recently concluded that ORS 656.268(7) does not mandate that only the medical arbiter's findings be considered in evaluating claimant's impairment. Timothy W. Reintzell, 44 Van Natta 1534 (1992). Rather, ORS 656.726(3)(f)(B) provides that under the standards, "impairment is established by a preponderance of medical evidence based upon objective findings." Accordingly, we disagree with SAIF's contention that the Referee was required to apply the arbiter's impairment findings.

However, we conclude that neither the impairment findings of claimant's treating physician nor those of the medical arbiter support an award for loss of grip strength. Former OAR 436-35-110(3) provides that an award of grip strength may be made if the decrease in strength is attributable to nerve damage, atrophy or anatomical change.

In his October 21, 1991 report, Dr. Stanford, the medical arbiter, noted that claimant's grip strength was reduced on the right as compared to the left. He reported, however, that it was "not clear * * * why her grip strength is decreased except for the fact that she has discomfort at this right wrist." (Ex. 24). Accordingly, Dr. Stanford's report is insufficient to support an award for loss of grip strength.

On August 1, 1990, claimant's treating physician, Dr. Corsolini, M.D., reported that claimant had much less strength in the right arm "but also showed an erratic pattern in the maximal voluntary effort test, which can be associated with less than full effort." In October 1990, Dr. Corsolini reported that nerve conduction studies of claimant's right wrist and elbow were negative for any evidence of entrapment neuropathy.

In April 1991, Dr. Corsolini found that claimant's strength testing was grossly normal "except for mildly reduced grip strength in the right hand." Dr. Corsolini diagnosed probable tendinitis at the right wrist tendon.

On June 4, 1991, Dr. Corsolini examined claimant and measured "20 pounds grip strength on the right side." He stated that the measurement was extremely low, and "without a physical deformity in the joints of the hands or fingers it is hard to visualize her true strength being that low." Dr. Corsolini again questioned the validity of the test and the "apparent discrepancy" in strength between the two hands. He repeated his concern about a less than full effort by claimant on the strength test and concluded that, other than pain from tendinitis in the wrist, "there is no discrete nerve lesion responsible for this problem" and "no objective impairment is present in the right arm."

Claimant urges us to find that tendinitis or an inflammatory process constitutes an anatomical change. However, even if we were to find medical evidence in the record to support such a conclusion, it is clear from the record that Dr. Corsolini does not accept his findings as indicative of claimant's "true strength." Under the circumstances, we reverse the Referee's award of an impairment value for loss of grip strength.

ORDER

The Referee's order dated February 19, 1992 is modified. The Order on Reconsideration award is reinstated and claimant's total award to date is 4 percent (6 degrees) scheduled permanent disability for loss of use or function of her right forearm.

October 1, 1992

Cite as 44 Van Natta 2057 (1992)

In the Matter of the Compensation of
JOHN D. McCOLLUM, Claimant
Own Motion No. 92-0445M
OWN MOTION ORDER
Malagon, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable injury that resulted in a heart condition injury. Claimant's aggravation rights expired on May 9, 1980. SAIF recommends that we authorize the payment of temporary disability compensation. SAIF also requests authorization for reimbursement from the Reopened Claims Reserve. Claimant requests the Board award a penalty of 25 percent of all temporary total disability due as a result of this order.

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 July 8, 1991, the date he was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-12-055.

SAIF also requests the Board to authorize reimbursement from the Reopened Claims Reserve pursuant to ORS 656.625(b). The Court of Appeals has held that the Board lacks the authority to grant or deny reimbursement from the Reserve. See SAIF v. Holmstrom, 113 Or App 242 (1992). Accordingly, we are unable to grant SAIF's request.

Penalties may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10)(a); ORS 656.882(1). The reasonableness of a carrier's action must be gauged based upon the information available to the carrier at the time of its action. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

Here, on November 4, 1991, claimant requested the reopening of his claim for medical services and temporary total disability. On January 31, 1992, SAIF denied medical benefits contending that

claimant's mitral valve replacement was not compensable. Claimant requested a hearing and an Opinion and Order was issued on June 26, 1992 which set aside SAIF's denial and found the denial was unreasonable and assessed a penalty. The Opinion and Order was not appealed. However, SAIF did not submit claimant's claim for own motion relief until September 10, 1992.

OAR 438-12-030 requires that the insurer, within 90 days of receiving an own motion claim, make a written recommendation to the Board as to whether the claim should be reopened or denied. SAIF failed to do so. Under these circumstances, we find that SAIF's action constitutes unreasonable resistance to the payment of compensation.

Although we have found SAIF's action unreasonable, we find no amounts "then due" on which to base a penalty. ORS 656.262(10)(a). When a claim is under own motion jurisdiction, no compensation is due claimant until we issue an order reopening the claim. Thus, a penalty cannot be assessed under ORS 656.262(10)(a). See Frederick D. Oxford, 42 Van Natta 476 (1990). On the other hand, where, as here, we find that a carrier has unreasonably resisted the payment of compensation, we may assess an attorney fee in the absence of amounts of compensation "then due." See ORS 656.382(1); Nicolasa Martinez, 43 Van Natta 1638 (1991). Accordingly, for SAIF's unreasonable resistance to the payment of compensation, we assess a penalty-related attorney fee of \$750.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed \$1,050, payable by SAIF directly to claimant's attorney. See OAR 438-15-010(4); 438-15-080.

IT IS SO ORDERED.

October 2, 1992

Cite as 44 Van Natta 2058 (1992)

In the Matter of the Compensation of
ESTHER C. ALBERTSON, Claimant
WCB Case No. 91-15728
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Moller and Neidig.

The insurer requests review of those portions of Referee McCullough's order that: (1) awarded claimant temporary total disability from January 13, 1991 through April 14, 1991; and (2) directed it to pay claimant's scheduled permanent disability award at the rate of \$305 per degree. In her brief, claimant argues that she was not medically stationary until August 27, 1991. On review, the issues are temporary total disability, medically stationary date, 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

Temporary Total Disability

The insurer initially paid claimant temporary total disability from September 4, 1990 through April 14, 1991. After an Order on Reconsideration awarded claimant scheduled permanent partial disability, the insurer offset from the permanent disability award that portion of temporary total disability payments that it had made from January 13, 1991 through April 14, 1991.

The Referee found that claimant was entitled to temporary total disability for the period of January 13 through April 14, 1991. The insurer challenges that conclusion, asserting that, although she

had not yet been declared medically stationary, in the absence of an authorization for time loss, claimant was not entitled to temporary total disability.

Although a claimant's procedural entitlement for all periods of time during an open claim is contingent upon authorization by the attending physician of temporary disability, see OAR 436-30-036(1), there is no such requirement for determining a claimant's substantive entitlement to temporary disability benefits. Rather, a claimant's substantive entitlement to temporary total disability is determined on claim closure and is proven by a preponderance of the evidence in the entire record showing that the claimant was disabled due to the compensable claim before being declared medically stationary. ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992).

Therefore, we do not regard the absence of an authorization for time loss by claimant's attending physician to be fatal to her claim for substantive temporary total disability benefits. Instead, we find that the Referee properly considered the entire record in determining claimant's disability prior to the medically stationary date, and we affirm and adopt that portion of his order finding that claimant was entitled to temporary total disability benefits for the period of January 13 through April 14, 1991.

Medically Stationary Date

As she did at hearing, claimant asserts that she proved that she was medically stationary on August 27, 1991 rather than April 15, 1991. We also affirm and adopt that portion of the Referee's order finding that claimant was medically stationary on April 15, 1991.

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 date of injury rule of ORS 656.202 to apply to the amendment of ORS 656.214(2), so that the increased rate of compensation applies 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 at the rate in effect at the time of the compensable injury. ORS 656.202(2); former ORS 656.214(2).

Attorney Fees on Review

Claimant's attorney is entitled to an assessed attorney fee for prevailing against the insurer's request for review regarding claimant's entitlement to temporary disability benefits for the period of January 13 through April 14, 1991. 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 \$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 February 4, 1992 is affirmed in part and reversed in part. That portion of the order that directed the insurer to pay claimant's scheduled permanent disability benefits at the rate of \$305 per degree is reversed. Claimant is entitled to be paid scheduled permanent disability at the rate in effect at the time of the compensable injury. The remainder of the Referee's order is affirmed. For services on Board review regarding the temporary disability issue, claimant's attorney is awarded an assessed fee of \$800, to be paid by the insurer.

In the Matter of the Compensation of
RONALD L. EAGON, Claimant
 WCB Case Nos. 91-14044, 91-07389, 91-07388 & 91-14043
 ORDER ON REVIEW
 John E. Uffelman, Claimant Attorney
 David Lillig (Saif), Defense Attorney
 Williams, et al., Defense Attorneys

Reviewed by Board Members Moller and Brazeau.

The SAIF Corporation requests review of Arbitrator Mills' order that: (1) set aside its responsibility denial of claimant's back condition; and (2) upheld Liberty Northwest Insurance Corporation's responsibility denial of the same condition. In his brief, claimant asserts that he is entitled to a penalty and attorney fees for SAIF's allegedly unreasonable stay of compensation pending review. On review, the issues are responsibility and stay of compensation.

We affirm and adopt the Referee's order with the following supplementation regarding the stay-of-compensation issue.

Claimant alleges in his respondent's brief that SAIF has improperly stayed the payment of compensation pending our review of this matter. Our review is confined to the issues presented at hearing. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). If claimant believes that SAIF's refusal to pay benefits warrants a penalty and related fee, then claimant should commence a new proceeding raising this as an issue. We decline to consider it at this stage of our review.

Claimant seeks an assessed attorney fee on review. The record establishes that claimant's temporary disability rate is higher with SAIF than with Liberty. (Ex. 49A). Therefore, claimant's compensation was at risk of reduction in the event that SAIF's appeal was successful. Inasmuch as claimant's compensation would have been reduced had SAIF prevailed on its request, claimant is entitled to a carrier-paid fee for services on review. ORS 656.382(2); International Paper Company v. Riggs, 114 Or App 203 (1992). 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 \$750, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's statement of services and respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Arbitrator's order dated January 23, 1992 is affirmed. Claimant's attorney is awarded \$750 for services on Board review, to be paid by the SAIF Corporation.

October 2, 1992

Cite as 44 Van Natta 2060 (1992)

In the Matter of the Compensation of
TIMOTHY W. MOORE, Claimant
 WCB Case No. C2-02241
 ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
 Emmons, Kropp, et al., Claimant Attorneys
 Kevin L. Mannix, P.C., Defense Attorney

Reviewed by Board Members Neidig and Moller.

On September 14, 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 total "consideration" for the agreement is the carrier's "waiver of recovery of a \$6,399.00 overpayment." The CDA further provides that no cash is to be paid to claimant or claimant's attorney.

Although the parties have not described the nature of the overpayment in their agreement, we presume the overpayment alluded to refers to overpaid temporary disability which the carrier was legally obligated to pay pursuant to ORS 656.210 and/or ORS 656.212. We have previously held that, where an overpayment has been apparently made pursuant to prior claims processing obligations, that overpayment cannot logically qualify as "proceeds" of the parties' CDA. See Raymond E. Clonkey, 43 Van Natta 1897 (1991).

Moreover, although the carrier is precluded, as a practical matter, by the parties' agreement from recovery by future offset of its overpayment, such preclusion does not convert the overpayment into "agreement proceeds." In this regard, a carrier may only recoup an overpayment from a future award, if any, of permanent disability. Therefore, a carrier's recovery of an overpayment is always speculative in that it is dependent upon a condition subsequent. For this reason, we conclude that a carrier's contractual forbearance of its speculative right to pursue an offset in the future cannot qualify the amount of the overpayment as "agreement proceeds." See e.g., Raymond E. Clonkey, *supra*.

Accordingly, consistent with the rationale expressed in Clonkey, *supra*, and because the proposed agreement provides for no other consideration for claimant's release of his workers' compensation benefits, we find that the CDA is unreasonable as a matter of law. Consequently, we decline to approve it.

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of any temporary or permanent disability that was stayed by the submission of the proposed disposition. OAR 436-60-150(4)(i) and (6)(e).

IT IS SO ORDERED.

October 5, 1992

Cite as 44 Van Natta 2061 (1992)

In the Matter of the Compensation of
ZODELLE L. HALBERG, Claimant
WCB Case No. 90-22039
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

On September 11, 1992, we withdrew our August 19, 1992 order which affirmed a Referee's order that upheld the insurer's denial of claimant's proposed knee surgery request. We took this action to consider claimant's contention that "this claim was resolved in its entirety by way of a Disputed Claim Settlement.

In response to our abatement order, the parties have submitted a December 1991 Disputed Claim Settlement (DCS), which resolved a dispute that was pending before the Hearings Division regarding claimant's "patellar tracking malalignment condition." WCB Case No. 91-12167. Pursuant to the DCS, the parties agreed that all issues raised or raisable had been settled.

Furthermore, the parties have submitted a "Stipulated Settlement," which is designed to resolve a dispute pending between them regarding the payment of certain medical bills. In accordance with the stipulation, the parties further agree that all issues raised or raisable have been resolved. Finally, the parties stipulate that this case may be dismissed with prejudice.

By this order, we have approved those portions of the DCS which pertain to issues pending in this case. In addition, we have approved the parties' stipulation. Consequently, these disputes have been fully and finally resolved. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN J. ALCANTAR, Claimant
WCB Case Nos. 87-18551, 87-01266 & 88-01581
ORDER ON REMAND
Callahan & Gardner, Claimant Attorneys
Lindsay, et al., Defense Attorneys
Roberts, et al., Defense Attorneys
Daryll E. Klein, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Castle & Cooke v. Alcantar, 112 Or App 392 (1992). We have been directed to reconsider this case in accordance with the court's reasoning.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee found Castle & Cooke (C & C) responsible for claimant's condition because she found that the 1982 injury with C & C was a material contributing cause of claimant's back condition until October 23, 1987. We initially reversed the Referee's order, finding that claimant's work at AIAC's insured, and not the 1982 C & C injury, was the cause of claimant's back condition in 1986. We further found that claimant had established a new occupational disease claim against AIAC because the employment exposure at AIAC's insured independently contributed to a worsening of the underlying back condition. Consequently, we held that responsibility shifted to AIAC.

On reconsideration, we found that C & C had waived its causation defense by raising only responsibility at hearing. John J. Alcantar, 42 Van Natta 406 (1990). We further concluded that responsibility remained with C & C because we found that no medical evidence indicated that claimant's work for AIAC's insured had independently contributed to a worsening of the underlying condition. In our Second Order on Reconsideration, we essentially affirmed the holding in our Order on Reconsideration that C & C had waived its causation defense by not raising compensability at hearing. John J. Alcantar, 42 Van Natta 617 (1990).

The court reversed, reasoning that a concession of compensability admits only that a claimant's condition resulted from a work exposure and does not operate to waive an employer's right to argue that the disability is not related to a work exposure in its employment. In accordance with the court's holding, we determine what carrier, if any, is responsible for claimant's 1986 disability.

As we found in our prior orders, the causation of claimant's 1986 back condition is a complex medical question which must be resolved by expert medical evidence. Uris v. Compensation Dept., 247 Or 420 (1967).

On reconsideration, we find that claimant's 1982 accepted claim with C & C is not a material contributing cause of his back condition in 1986. We base this conclusion on the following reasoning.

Claimant suffered a nondisabling back strain injury in 1982 at C & C. Although claimant has had intermittent pain since the 1982 injury, he sustained no permanent impairment, missed no work and sought no medical treatment between late 1982 and April 1986. Moreover, both Dr. Shorb, D.C., who treated claimant for his back condition in November 1986, and Dr. Pollard, an orthopedic surgeon, opined that claimant's 1986 back condition was not materially related to the 1982 claim with C & C.

We note that Dr. Nickila, who also treated claimant in 1986, relates claimant's back disability to the 1982 injury. However, soon after rendering that opinion, Dr. Nickila indicated on a check-the-box form that claimant's back disability was related to his work exposure in September and October of 1987 rather than the 1982 injury. We find Nickila's opinion to be inconsistent and inadequately explained, therefore we find it unpersuasive. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980).

Claimant was also examined in February 1988 by Drs. Halferty, Gardner and Short of the Orthopaedic Consultants. They felt that claimant's symptoms were related to the sustained positions of forward reaching and continuous heavy lifting at work. They further opined that his symptoms have been continuous since July 1982. We find the Orthopaedic Consultants' opinion unpersuasive due to the fact that it is based on an inaccurate history. See Miller v. Granite Construction, 28 Or App 473, 476 (1977). The Consultants mistakenly understood that claimant had occasionally missed work because of chronic pain from the 1982 injury. Claimant did not, in fact, miss work due to the 1982 C & C injury.

We find no persuasive reason not to defer to Dr. Shorb's opinion regarding the causation of claimant's 1986 back condition. Weiland v. SAIF, 64 Or App 810, 814 (1983). In addition, his opinion that the 1982 injury was not a material contributing cause of the 1986 condition is supported by Dr. Pollard. Based on the evidence summarized above, we find no causal relationship between the 1982 injury and claimant's back condition between April 1986 and October 23, 1987. We further find that although claimant experienced periodic back pain after 1982, the 1982 C & C injury had essentially resolved prior to 1986. Accordingly, the condition which arose in 1986 is not compensable as to C & C.

We next address the compensability of claimant's 1986 back condition as to AIAC. As we noted in our prior orders, claimant described his back pain in 1986 as coming on gradually without any specific identifiable injury and resulting from repetitive work activities which required bending. Therefore, although Dr. Shorb characterizes the November 1986 disability and need for treatment as an "injury," claimant's back condition in 1986 is properly analyzed as an occupational disease. See Valtinson v. SAIF, 56 Or App 184 (1982); O'Neal v. Sisters of Providence, 22 Or App 16 (1975).

In order to prevail on an occupational disease claim, claimant must show that the work activities were the major contributing cause of the condition, or in the case of a preexisting condition, that the work activities were the major contributing cause of a worsening of the underlying condition. Weller v. Union Carbide, 288 Or 27 (1979). Since we have already concluded that claimant's 1982 back condition had resolved, claimant need only show that his work for AIAC's insured was the major contributing cause of the back condition in November 1986.

On November 23, 1988, Dr. Shorb stated that the 1986 back condition was primarily the result of claimant's current work activities and not his 1982 injury. On January 25, 1988, Dr. Shorb opined that the major contributing cause of claimant's 1986 condition was claimant's work cleaning floors at AIAC's insured in November 1986. Based on Dr. Shorb's opinion, we conclude that claimant has established a compensable occupational disease against AIAC. Accordingly, AIAC is responsible for claimant's back condition from November 1986 until October 23, 1987.

In the alternative, assuming that the 1982 injury never fully resolved, we find Dr. Shorb's opinion sufficient to prove a worsening of the underlying back condition. Shorb opined that the major contributing cause of claimant's disability and need for medical treatment in November 1986 was claimant's employment at AIAC's insured. In rendering his opinion, Dr. Shorb was aware of claimant's 1982 injury and the intermittent pain caused by that injury. Under these circumstances, we interpret his opinion as indicating that claimant's employment in November 1986 was the major contributing cause of a worsening of his underlying back condition. Thus, responsibility for claimant's condition would shift to AIAC. Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986).

On reconsideration, the Referee's order dated May 2, 1988 is reversed in part and affirmed in part. C & C's denial is reinstated and upheld. AIAC's denial is set aside and the claim remanded to AIAC for processing according to law. AIAC shall pay the attorney fee granted by the Referee to be paid by C & C, as well as the \$200 carrier-paid attorney fee granted by our prior orders. The remainder of the Referee's order is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
WARREN N. BOWEN, Claimant
WCB Case No. 91-15616
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of that portion of Referee Nichols' order which awarded a \$1,000 attorney fee for prevailing over its denial of the compensability of claimant's medical treatment. Claimant cross-requests review of that portion of the Referee's order which declined to assess penalties or related attorney fee for an allegedly unreasonable denial. On review, the issues are penalties and attorney fees.

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

On review, SAIF contends that claimant was not entitled to an attorney fee at the hearing level because claimant has not overcome all legal theories advanced by the denial. SAIF further asserts that, according to prior legal precedent, where a denial has multiple legal defenses, claimant is only entitled to an assessed fee under ORS 656.386 if he prevails on all theories. See, e.g., Anthony J. Colistro, 43 Van Natta 1835 (1991) (Where, under the law prior to the 1990 amendments, we held that when the insurer denied both the causal relationship and the reasonableness and necessity of the medical treatment, a claimant was not entitled to an attorney fee unless he prevailed over both elements of the denial).

After the 1990 amendments, original jurisdiction over disputes between the insurer and the injured worker concerning medical treatment that is allegedly "excessive, inappropriate, ineffectual or in violation of the regarding performance of medical services" lies exclusively with the Director. Stanley Meyers, 43 Van Natta 2643 (1991). The Board retains original jurisdiction only over disputes concerning whether the treatment is causally related to the compensable injury. Michael A. Jaquay, 44 Van Natta 173 (1992).

Here, in light of the aforementioned holdings, the Referee's authority was solely confined to a determination as to whether the disputed treatment was causally related to claimant's compensable injury. In other words, the sole theory before the Referee was the disputed causal relationship. Inasmuch as claimant prevailed against that theory and since that theory was the only one which the Referee could consider, claimant is entitled to an attorney fee award under ORS 656.386(1).

In reaching our decision, we note that SAIF also cites Greenslitt v. City of Lake Oswego, 305 Or 530 (1988) in support of its position. In Greenslitt, the Court held that a claimant "prevails finally" before a forum if that forum holds in the claimant's favor on the issue of the claimant's right to workers' compensation and that determination is not appealed within the time allowed by statute. In this case, we have held in claimant's favor on the only issue of claimant's right to compensation which is properly before us. Accordingly, under the requirements of Greenslitt, we conclude that claimant has finally prevailed in this forum and is therefore entitled to a fee.

Inasmuch as attorney fees are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an attorney fee for services on Board review. 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 February 21, 1991 is affirmed.

In the Matter of the Compensation of
JAMES F. HERRON, Claimant
WCB Case Nos. 92-05951, 91-18372 & 92-03965
ORDER DENYING MOTION TO DISMISS
Coons, et al., Claimant Attorneys
Mitchell, et al., Defense Attorneys
Cowling & Heysell, Defense Attorneys
Charles Lundeen, Defense Attorney

American States Insurance Company, on behalf of L & S Tire, has moved to dismiss a request for Board review of a Referee's order filed by Liberty Northwest Insurance Corporation's, on behalf of Joe Romania Chevrolet. Noting that Liberty's request for review identifies "compensability" as an issue on review, American seeks dismissal of the request because Liberty "conceded the compensability issue at the outset of the hearing." The motion is denied.

FINDINGS OF FACT

On August 11, 1992, the Referee issued an Opinion and Order. Pursuant to that order, the Referee: (1) set aside Liberty's denials of claimant's claim for a right elbow condition; (2) upheld Crawford & Company's denial of claimant's claim for the same condition; and (3) upheld American's responsibility denial for the same condition.

On September 3, 1992, Liberty mailed, by certified mail, its request for review of the Referee's order to the Board. The request provided that "[t]he reason review is requested is the Referee made errors of fact finding and errors of law regarding compensability."

Liberty also mailed copies of its request to the other parties on that same day. On September 9, 1992, the Board mailed a computer-generated letter to all parties acknowledging the request for review.

CONCLUSIONS OF LAW

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

A request for Board review of a Referee's order need only state that the party requests a review of the order. ORS 656.295(1). The statute is incorporated by reference into the Board's procedural rules. See OAR 438-11-005(1). Considering the clear directive of ORS 656.295, we have previously held that we are not authorized to limit our jurisdiction to less than that provided by the statute. See Kimberly L. Murphy, 41 Van Natta 847 (1989).

In Murphy, we denied a motion to dismiss a request for Board review based on a party's failure to state a reason for the request as provided in OAR 438-11-005(3). We reasoned that the rule was an informational aid and, in light of ORS 656.295(1), we were not authorized to limit our jurisdiction to consider a request that failed to comply with the rule.

Here, American argues that Liberty's request should be dismissed because it lists "compensability" as an issue, even though Liberty had conceded that issue at hearing. It does appear that Liberty contested only responsibility for the claim at hearing. Nevertheless, regardless of whether Liberty's request accurately reflects the issue for resolution on Board review, the fact remains that Liberty timely requested review of the Referee's order. Consistent with ORS 656.295 and Murphy, we are without authority to dismiss such a request.

Accordingly, American's motion to dismiss is denied. A transcript of the oral proceedings has been ordered. Upon its receipt, copies will be distributed to the parties along with a briefing schedule. Thereafter, the case will be docketed for Board review.

IT IS SO ORDERED.

In the Matter of the Compensation of
FRANCES R. KEENON, Claimant
WCB Case Nos. 90-01740, 89-25793, 89-25794 & 90-01739
ORDER ON REMAND
Richard A. Sly, Claimant Attorney
Julene Quinn (Saif), Defense Attorney
Charles Lundeen, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Keenon v. Employers Overload, 114 Or App 344 (1992). The court has reversed that portion of our prior order, Frances R. Keenon, 43 Van Natta 1325 (1991), which did not award claimant's attorney a fee for services rendered before the issuance of an order designating a paying agent under ORS 656.307. Noting that the SAIF Corporation had conceded that attorney fees should have been allowed for such services, the court has remanded for reinstatement of claimant's attorney fee award for those services.

The Arbitrator awarded claimant's attorney a carrier-paid fee of \$5,743.75 to be paid by SAIF. As detailed in the Arbitrator's June 5, 1990 Opinion and Order and May 29, 1991 Interim Order on Remand, this award pertained to the issues of "responsibility, unreasonable denial, and late discovery."

We affirmed those portions of the Arbitrator's order which concluded that SAIF's denial was unreasonable and that SAIF had provided discovery in an untimely manner. We reversed the Referee's attorney fee award insofar as it pertained to the responsibility issue, reasoning that claimant had not meaningfully participated because she had not contended that any particular insurer was the responsible party. Notwithstanding these conclusions, our order neglected to determine the amount of claimant's attorney fee award for the unreasonable denial and late discovery issues.

Claimant petitioned for judicial review of our order. Before the court, claimant contended that her counsel was entitled to an attorney fee for services rendered before and after the issuance of the "307" order. In addition, she asserted entitlement to an attorney fee award concerning the unreasonable denial and late discovery issues. In response, SAIF conceded that claimant's attorney was entitled to a fee for services rendered prior to issuance of the "307" order, as well as for services performed relating to the "claims processing errors." However, SAIF contested claimant's entitlement to an attorney fee for services rendered after the "307" order because claimant did not "meaningfully participate" in the hearing.

The court affirmed that portion of our order which held that claimant was not entitled to an attorney fee under ORS 656.307 for her participation in the arbitration proceeding. Nevertheless, accepting 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," the court remanded "for reinstatement of the award for those services."

Based on claimant's counsel's statement of services and time records, we find that claimant's attorney and legal staff expended approximately 16 hours of service prior to issuance of the "307" order. According to the aforementioned records, the total amount of services rendered through the arbitration proceeding were approximately 50 hours. Consequently, roughly 32 percent of claimant's counsel's services pertained to "pre-307" duties. Inasmuch as the Referee awarded \$5,743.75, we find that a reasonable fee for claimant's attorney's "pre-307" services is \$1,838 (32 percent of \$5,743.75).

In reaching this conclusion, we have considered the factors set forth in OAR 438-15-010(4). In particular, we have particularly considered the time devoted to the case, the value of the interest involved, the complexity of the issue presented, and the risk that claimant's attorney might go uncompensated.

Finally, as discussed above, we previously found that claimant was entitled to attorney fee awards for SAIF's unreasonable denial and discovery violation. Notwithstanding these findings, our prior order neglected to award attorney fees concerning these issues. SAIF has not contested these findings. In fact, it has conceded that claimant is entitled to an attorney fee award for "services performed relating to claims processing errors." (Respondent's Brief, Page 10). Moreover, the court has not disturbed our conclusions concerning these issues.

Under such circumstances, we proceed to determine a reasonable attorney fee award for claimant's counsel's services regarding the unreasonable denial and late discovery issues. After considering the factors set forth in OAR 438-15-010(4), we find that a reasonable attorney fee award for the unreasonable denial issue is \$750 and for the late discovery issue is \$250. In reaching these conclusions, we have particularly considered the time devoted to the issues (as demonstrated in claimant's counsel's statement of service, time records, and the hearings record), the value of the interests involved, the complexity of the issues, and the risk that claimant's counsel might go uncompensated.

Accordingly, claimant's attorney is awarded insurer-paid fees payable by SAIF totalling \$2,838 for services rendered prior issuance of the "307" order, SAIF's unreasonable denial, and SAIF's discovery violation.

IT IS SO ORDERED.

October 6, 1992

Cite as 44 Van Natta 2067 (1992)

In the Matter of the Compensation of
ARLENE J. KOITZSCH, Claimant
WCB Case No. 90-13984
ORDER DENYING RECONSIDERATION
Craine & Love, Claimant Attorneys
Schultz & Taylor, Defense Attorneys

Claimant requests reconsideration of our April 14, 1992 Order on Reconsideration that affirmed a Referee's order which awarded claimant 34 percent (51 degrees) scheduled permanent disability for a right forearm condition. Contending that our refusal to rely on the impairment finding made by claimant's attending physician is contrary to several recent Board decisions, claimant asks that we withdraw our prior order for further consideration.

Claimant 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 claimant's request, we decline to reconsider our April 14, 1992 order. However, we offer the following additional comments concerning claimant's contention.

Claimant asserts that in affirming the Referee's permanent disability award we improperly relied on impairment findings from an independent medical examiner (IME). Such an assertion suggests a misinterpretation of our reasoning.

One portion of our conclusion does state that the IME "persuasively rebutted" the sensory deficit finding reported by Dr. Johnson, the alleged attending physician. Nevertheless, the primary thrust of our decision was that, assuming without deciding that Dr. Johnson was claimant's attending physician, his opinion and impairment findings are not persuasive because they are unexplained, conclusory, not in compliance with established guidelines, and internally inconsistent. Thus, irrespective of our reference to the IME, Dr. Johnson's opinion and findings do not support a permanent disability award beyond the 34 percent granted by the Referee.

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 545 (1985).

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT J. LARRY, Claimant
WCB Case No. 91-01036
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Lipton's order that upheld the self-insured employer's "de facto" denial of his aggravation claim. The employer cross-requests review of that portion of the Referee's order which set aside its "de facto" denial of claimant's current condition and need for medical treatment. On review, the issues are perfection of an aggravation claim and compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Aggravation

The Referee found that the July 16, 1990 chart note by Dr. Weintraub was insufficient to establish an aggravation claim because the condition requiring treatment was no more than a waxing and waning of symptoms contemplated by the previous permanent disability award. See ORS 656.273(8). We agree that the July 16, 1990 chart note did not establish an aggravation claim, but we disagree with the basis for the Referee's conclusion.

The Referee found that the July 1990 condition was a waxing and waning contemplated by the previous award of permanent disability based on claimant's prior history of similar flare-ups. However, a history of past flare-ups alone is insufficient evidence on which to base a finding that a worsening was no more than a waxing and waning of symptoms contemplated by the previous award of permanent disability. Lucas v. Clark, 106 Or App 687 (1991). There must also be medical evidence predicting such flare-ups. Id.

Here, no medical evidence predicts waxing and waning prior to the December 11, 1987 stipulation which increased claimant's unscheduled permanent disability award to 20 percent. Furthermore, the December 11, 1987 stipulation did not mention the possibility of future waxing and waning of claimant's low back condition. Accordingly, we disagree with the Referee's conclusion that claimant's worsening constituted a waxing and waning of symptoms contemplated by the previous permanent disability award. However, we nevertheless find that the chart note is insufficient notice of a worsened condition.

The July 16, 1990 chart note from Dr. Weintraub provides, in part:

"[Claimant] has not been in for quite some time. He has had a recent flare-up of his back and leg bothering him. It has diminished over the last couple of weeks. He is working * * * and has had no difficulties in this new job * * * He has continuing problems referable to his old back strain and L5-6 disc problem. I do not think he needs any treatment specifically at this time. He is to continue working."

In order to establish an aggravation claim pursuant to ORS 656.273(3), "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." Herman M. Carlson, 43 Van Natta 963, 964 (1991). The report must also establish a causal connection between claimant's noted condition and compensable injury. Carlson, supra at 964; Michael L. Page, 42 Van Natta 1690, 1693 (1990). Finally, the physician's report must put the insurer on notice that the treatment is for worsened, not continuing, conditions. Linda Coiteux, 43 Van Natta 364 (1991).

The July 16, 1990 chart note states only that claimant was having continuing problems related to his old injury. It also indicates that no treatment was necessary and that claimant was to continue working. Accordingly, we find this chart note insufficient to give notice of a claim for a worsened condition. Linda Coiteux, supra. In light of this conclusion, we decline to consider the employer's contention that the chart note could not constitute an aggravation claim because it was untimely filed with the employer.

Compensability of Current Condition/Need for Treatment

We adopt the reasoning and conclusions as set forth in the Referee's order concerning the compensability of claimant's current condition and need for medical treatment with the following supplementation.

On review, the employer argues that the medical histories of Drs. Rosenbaum and Weintraub are inaccurate and that, accordingly, their opinions based on those histories should not be relied upon. Specifically, the employer contends that the emergency room report indicates that the September 29, 1990 incident in which claimant stepped down from looking into the window of a house and jolted his back, caused instant pain, while Drs. Rosenbaum and Weintraub were told that the pain started an hour to an hour and a half after the incident.

We do not find the histories obtained by Rosenbaum and Weintraub to be inaccurate. The emergency room report contains two apparently contradictory notations in different handwriting. One says that the pain was instant while the other notation describes the September 29 incident and states: "no pain initially but since left low back pain to mid calf."

Considering the contradictory emergency room report, we are not persuaded that the opinions rendered by Dr. Rosenbaum and Dr. Weintraub should be discounted based on inaccurate histories. We agree with the Referee's conclusion that all of the medical evidence supports a finding that the major contributing cause of claimant's current condition is the 1984 compensable injury.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer's cross-request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is \$750, to be paid by the self-insured employer. 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.

ORDER

The Referee's order dated November 4, 1991 is affirmed. For services on review concerning the compensability issue, claimant's attorney is awarded \$750 payable by the employer.

October 6, 1992

Cite as 44 Van Natta 2069 (1992)

In the Matter of the Compensation of
LIZBETH MEEKER, Claimant
WCB Case No. 91-09541
ORDER ON REVIEW
Becker, Hunt & Hess, Claimant Attorneys
Williams, Zografos, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Myers' order that: (1) upheld Liberty Northwest Insurance Corporation's denial of claimant's current condition; and (2) denied claimant's request for penalties and attorney fees for Liberty's allegedly unreasonable failure to pay medical bills. On review, the issue is compensability, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant has worked approximately 25 years in the field of textile conservation, which involves weaving, spinning and sewing of textile art. In April 1988, she began working for the employer restoring antique rugs. Her work involved replacing warp or weft threads, reknitting pile and reweaving worn areas.

In July 1988 claimant first noticed hand problems while working on a stair runner. She particularly noticed problems with her left thumb, which she had hyperextended playing softball in high school. On September 13, 1988, she sought treatment from Dr. McNeil, who provided conservative treatment. Her symptoms continued and, in February 1989, she was referred to Dr. Podemski, a neurologist. Dr. Podemski reported that claimant's symptoms suggested mild carpal tunnel syndrome, but added that nerve conduction studies were normal. Claimant continued regular work.

Following a period of improved symptoms, claimant returned to Dr. McNeil on February 9, 1991 with increased left thumb pain. She stopped working for the employer on February 14, 1990, and, the following day, filed a claim for "carpal tunnel and tendonitis," which she attributed to "repetitive hand motions with stress over a period of months, involving reknitting and reweaving old handmade rugs." (Ex. 10).

Before October 3, 1989, the employer carried no workers' compensation coverage. After that date, it was insured by Liberty. On March 27, 1990, Liberty accepted the claim for "BILATERAL OVERUSE/WITH TENDONITIS [sic] BOTH HANDS." (Ex. 14). Shortly thereafter, the Workers' Compensation Department issued an order declaring the employer to be a noncomplying employer prior to October 3, 1989, and referred the claim to the SAIF Corporation for processing. On May 24, 1991, SAIF denied the claim, asserting that Liberty was the responsible carrier.

On July 18, 1991, claimant filed requests for hearing against both Liberty and SAIF, raising numerous issues including compensability and medical services. At the commencement of the hearing, however, claimant withdrew his hearing request against SAIF pursuant to a settlement agreement. The hearing proceeded against Liberty, which conceded liability for treatments rendered during its coverage, but verbally denied the compensability of claimant's current condition.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant had failed to establish the compensability of her current condition, because she failed to prove that the accepted claim remained the major contributing cause of her current disability and need for treatment. Claimant contends that Liberty is bound by its initial acceptance of the claim and argues that its verbal denial is an impermissible back-up denial.

In Bauman v. SAIF, 295 Or 788 (1983), the insurer attempted to deny compensability of a previously accepted claim. The court held that it could not do so, explaining:

"The insurer or self-insured employer is not at liberty to accept a claim, make payments over an extended period of time, place the compensability in a holding pattern and then, as an afterthought, decide to litigate compensability." 295 Or at 793.¹

Unlike the insurer in Bauman, Liberty is not attempting to revoke its original acceptance of a claim. Rather, relying on ORS 656.005(7)(a)(B), it is attempting to limit its responsibility for claimant's current symptoms by asserting that the onset of the condition occurred in 1988, before it was on the risk. Specifically, Liberty contends:

"Claimant left her position at the employer in February of 1990. After leaving

¹ We note that the legislature modified the Bauman rule on retroactive denials during its 1990 Special Session. ORS 656.262(6). Given our conclusion that Liberty is not attempting to revoke its original acceptance of the claim, we need not address that provision.

her position, claimant filed a claim with the employer which was accepted for bilateral overuse with tendonitis of both hands. It was assigned a date of injury of October 3, 1989. Claimant's treating physician has concluded that her work on a floor runner in 1988, before Liberty came on the risk, is the cause of her current condition. * * * Claimant's condition preexisted the time when Liberty became the insurer. * * * Claimant's preexisting condition is unquestionably the major contributing cause of her need for disability or need for treatment." (Resp. brief at 2).

Claimant's current condition is the same condition--bilateral overuse with tendonitis--that Liberty accepted. The question, therefore, is whether Liberty may deny compensability of specific medical benefits and other claim expenses related to that condition on a theory that claimant's work activities for the employer before Liberty became the insurer are the cause of the condition. ORS 656.005(7)(a)(B) provides:

"If a compensable injury combines with a preexisting disease or condition to cause or prolong disability or a need for treatment, the resultant condition is compensable only to the extent the compensable injury is and remains the major contributing cause of the disability or need for treatment."

In Bahman M. Nazari, 44 Van Natta 831 (1992), we construed that provision as authorizing an insurer to limit the scope of an accepted injury claim by denying compensability for treatment and disability it reasonably believes is caused in major part by a preexisting condition. We conclude, however, that ORS 656.005(7)(a)(B) is not applicable here. This case involves an accepted occupational disease claim, as opposed to an accepted injury claim. That distinction is important because, while an occupational disease is generally considered as an injury pursuant to ORS 656.804, its compensability is determined under a separate statutory framework set forth in ORS 656.802 et seq. We find nothing in the plain language of ORS 656.007(5)(a)(B) to indicate that, in subjecting a compensable injury claim to certain limitations, the legislature intended to similarly limit occupational disease claims. Moreover, limiting the compensability of a preexisting condition in an accepted occupational disease claim is inconsistent with ORS 656.802(2), which requires proof that a preexisting condition was pathologically worsened in order for an occupational disease claim to be compensable. Weller v. Union Carbide, 288 Or 27 (1979).

Even if we assume that ORS 656.005(7)(a)(B) applies to an accepted occupational disease claim, we reject Liberty's contention that the compensable claim "combine[d] with a preexisting disease or condition to cause or prolong disability or a need for treatment[.]" The medical record reveals that claimant's condition for which she previously sought treatment is the same as the accepted condition. Thus, there is no preexisting disease; only a compensable occupational disease that Liberty accepted. Finally, if Liberty believed that a prior carrier was responsible for the compensable condition, the time to make that assertion was prior to its acceptance of the claim. ORS 656.308.

In short, we conclude that the limiting feature of ORS 656.005(7)(a)(B) is not applicable to an accepted occupational disease claim and, even if we assume that it is, there is no evidence that a preexisting condition has combined with the compensable condition to cause or prolong disability. Accordingly, Liberty's verbal denial must be set aside.

Penalties and Attorney Fees--Medical Bills

We adopt the Referee's conclusions and reasoning concerning this issue. After our review of the record, we too agree that there is no persuasive evidence that the medical bills at issue were submitted to Liberty.

Attorney Fees for Services at Hearing and on Review

Claimant is entitled to an assessed attorney fee for prevailing over Liberty's verbal denial of compensability. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability of claimant's current condition is \$2,800, to be paid by Liberty. 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 19, 1991 is affirmed in part and reversed in part. Liberty's verbal denial of claimant's current condition is set aside, and the claim is remanded to Liberty for further processing according to law. The remainder of the order is affirmed. For services at hearing and on Board review concerning the compensability issue, claimant's attorney is awarded an assessed attorney fee of \$2,800, to be paid by Liberty.

October 6, 1992

Cite as 44 Van Natta 2072 (1992)

In the Matter of the Compensation of
DELARIS A. PEACOCK, Claimant
WCB Case No. 91-11568
ORDER ON REVIEW
Charles G. Duncan, Claimant Attorney
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerbund.

Claimant requests review of Referee Daughtry's order that upheld the SAIF Corporation's partial denial of claimant's medical services claim for her current sinusitis and rhinitis condition. On review, the issue is compensability of claimant's current condition. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the last two sentences.

CONCLUSIONS OF LAW AND OPINION

The Referee was not persuaded that claimant's 1985 compensable chemical sensitivity was the major contributing cause of her current nose, throat, eye, ear, and headache symptoms. Consequently, the Referee upheld SAIF's denial of claimant's current condition. We disagree and reverse.

The medical evidence is divided. Dr. Morgan, former treating allergist, was unable to comment on claimant's current condition, because he last saw her in 1978. (Ex. 11). Dr. Bardana, independent examiner, conducted a file review and opined that claimant's work exposure did not aggravate her preexisting chronic sinusitis and rhinitis. (See Ex. 1-3). We discount his opinion, because it is contrary to the law of the case since those preexisting conditions were previously found to be compensable. See Kuhn v. SAIF, 73 Or App 768, 772 (1985).

Dr. Stark, independent examiner, reviewed claimant's history and examined her on February 16, 1990. Stark agreed with Bardana that there is no evidence that claimant "ever developed chemical susceptibility or sensitivity to chemicals or other materials at her place of work[.]" (Ex. 2-1). Stark noted claimant's history of over thirty years of sinus disease and current "classic" symptoms of allergic rhinitis and sinusitis. Although Stark acknowledged that claimant's work exposure in 1975 could have interacted with her allergic condition to produce worsened symptoms of that condition, she suspected that such a worsening would have been temporary, rather than permanent. To the extent that Stark's opinion is based on a belief that claimant's work-related problems were temporary, rather than permanent, we do not rely on it because it is contrary to the law of the case in that claimant has previously received 60 percent permanent disability award. See Kuhn v. SAIF, *supra*; see also Queener v. United Employer's Insurance, 113 Or App 364 (1992).

Dr. Worrell, in contrast, has treated claimant since she moved to Arizona in 1985. Worrell reported test results indicating that claimant has "problems with detoxification of chemicals." (Ex. 9-1). He noted: "evidence of chemical toxicity with peroxides and lipid endoperoxides. She also has [a]

decrease of Sulhydryls, suggesting that these compounds have been over utilized depleting her system of these protective antioxidants. She also has evidence of autoimmunity, most likely secondary to chemical sensitivity[.]" (*Id.*) Worrell's opinion supports a conclusion that claimant still suffers from her compensable chemical sensitivity condition and that her current condition remains related to her work exposure. (*See Exs. 3,4,6,7,9.*)

We defer to the opinion of claimant's treating physician, in the absence of persuasive reasons to do otherwise. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no such reasons. Accordingly, based on Worrell's opinion, we conclude that claimant has carried her burden of proving that her current sinusitis and rhinitis condition is compensable.

Claimant is entitled to an assessed attorney fee for prevailing on the medical services issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is \$3,000, 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 and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 20, 1991 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to it for further processing in accordance with law. For his services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of \$3,000, payable by SAIF.

October 6, 1992

Cite as 44 Van Natta 2073 (1992)

In the Matter of the Compensation of
ANGEL RAMIREZ, Claimant
WCB Case No. 90-19531
ORDER ON REVIEW
Michael Dye, Claimant Attorney
Schultz & Taylor, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of Referee Davis' order that set aside its denial of claimant's low back injury claim. With its brief, the insurer: (1) moves to strike a witness' telephone testimony; (2) objects to the Referee's exclusion of documentary and testimonial "impeachment" evidence; and (3) requests remand for admission and consideration of the excluded evidence. On review, the issues are evidence, remand and compensability.

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

Motion to strike

The insurer moves to strike the telephonic testimony of Roberto Ramirez, arguing that it should have an opportunity to confront the witness by cross-examining him in person. In support of its motion, the insurer further contends that no extraordinary circumstances justify telephone testimony in this case. *See* OAR 438-07-022.

Considering the uncontradicted evidence and averments regarding the out-of-state witness' financial circumstances, (*see* Tr. 43 & Ex. 9), we agree with the Referee's reasoning and conclusion that the Ramirez' inability to travel from Texas to Oregon to attend the hearing constitutes extraordinary circumstances which justify the taking of testimony by telephone. (*See* Tr. 29-32.) In addition, we note that the insurer did cross-examine the witness over the telephone before the Referee. (*See* Tr. 50-57). Under these circumstances, we conclude that the Referee did not abuse his discretion in permitting the

witness to testify by telephone. See Cheryl M. Hickox, 44 Van Natta 1264 (1992). See ORS 656.283(7). Accordingly, the motion to strike is denied.

Excluded evidence/remand

The insurer argues that the Referee erred in excluding the employer's accident investigation report regarding the August 7, 1990 incident involving claimant. We disagree.

OAR 438-07-018(4) vests the Referee with discretion to exclude documents not disclosed within the time prescribed by OAR 438-07-015 if there is prejudice to the other party. See also OAR 438-07-015(5). In this case, it is undisputed that the document was not timely disclosed, as required by OAR 438-070-015. Moreover, because the author of the report was not available for cross-examination, we find that claimant would have been prejudiced by its admission.

In reaching this conclusion, we note the insurer's argument that the document should be admitted as impeachment evidence and, as such, be exempted from the rule's disclosure requirements. However, we agree with the Referee that the report was "hearsay," offered for its substance, because facts concerning the state of the restroom are central to the merits of the claim. (See Tr. 120-126).

Hearsay evidence is generally admissible in workers' compensation proceedings, although such evidence may be excluded when it is in the interest of substantial justice to do so. See ORS 656.283(7); Armstrong v. SAIF, 67 Or App 498, 501 n.2 (1984); see also Marion R. Webb, 37 Van Natta 750, 751 (1985). In this case, the author of the report was unavailable for cross-examination. Because we find no indicia of the report's reliability, we conclude that its exclusion served the interests of substantial justice. Accordingly, we find no abuse of discretion in this regard. See Charles D. Spano, 43 Van Natta 1702, 1703 (1991) ("It is not error to exclude hearsay documents when the author is not available for cross-examination in the absence of strong indicia of reliability").

The insurer also argues that the Referee erred in sustaining claimant's objections to a witness' observations regarding claimant's pain behavior and his ability to understand English at hearing. (Tr. 127-130). The insurer contends that this evidence is relevant because it would reflect against claimant's credibility. We disagree, in part because the insurer fails to explain how a witness' opinion concerning claimant's demeanor and abilities at hearing is relevant to resolving a dispute about whether an injury occurred months previously. Moreover, as the Referee correctly explained, he is charged by law with evaluating witness' credibility. In this case, we see no reason to disturb the Referee's assertion that the excluded testimony by the employer's representative would not be helpful to him in this regard.

In summary, we uphold the Referee's evidentiary rulings as within his discretion and in the interests of substantial justice. In addition, we find no evidence that the record was "improperly, incompletely or otherwise insufficiently developed or heard by the referee[.]" ORS 656.295(5). Accordingly, the motion to remand is denied.

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 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 2, 1992 is affirmed. For his services on review, claimant's attorney is awarded an assessed fee of \$1,500, payable by the insurer.

In the Matter of the Compensation of
RALPH L. WITT, Claimant

WCB Case Nos. 90-22553, 90-22551, 91-00579, 90-22549, 90-22550, 90-22552, 91-00582, 91-00581, 91-05226,
91-05227, 91-08190, 90-03335, 91-08189 & 91-00580

ORDER ON REVIEW

Black, et al., Claimant Attorneys
Norm Cole (Saif), Defense Attorney
Snarskis, et al., Defense Attorneys
Kevin Mannix, P.C., Defense Attorneys
Terrall & Associates, Defense Attorneys
Mitchell, et al., Defense Attorneys

Reviewed by Board Members Moller and Westerband.

EBI Companies requests review of Referee Brown's order that: (1) found that EBI was barred from denying compensability and responsibility for claimant's occupational disease claim for asbestosis; and (2) in the alternative, found EBI responsible for the same condition. On review, the issue is the res judicata effect of a prior order and responsibility. We reverse in part and modify in part.

FINDINGS OF FACT

Claimant was self-employed through his company, Bear Creek Electric. Claimant stopped working in May 1988 due to his lung condition.

In 1987, the responsibility for claimant's lung condition was litigated before Referee Mongrain. Along with other carriers, EBI and Aetna were parties to the proceeding; EBI provided coverage for claimant's company from October 1, 1980 through September 30, 1982 and Aetna provided coverage from October 1, 1986 through May 1988. The hearing was limited to the issue of responsibility for claimant's "asbestos-related lung condition"; at the beginning of the hearing, EBI's attorney conceded compensability "of claimant's condition." (Ex. 67-1).

Referee Mongrain found that claimant had been exposed to asbestos during June, July and December 1976; February and June 1977; October 1977 through March 1978; August 1982 through January 1983; February 1984; March, April and May 1986; and July 1987. (Id. at 2). Referee Mongrain concluded that "claimant became disabled by his asbestos-related lung condition in 1984. At that point responsibility became fixed with EBI Companies[.]" (Id. at 3). The Referee set aside EBI's denial and remanded the claim for acceptance. The order subsequently was amended to include the Referee's finding that claimant proved that his "asbestos-related lung condition was not independently worsened by exposure subsequent" to EBI's period of coverage. (Ex. 68-1). Following a motion for reconsideration by EBI, the order and amendment were republished in their entireties. (Ex. 69A-1).

Although claimant filed a request for review regarding the order, he did not challenge the Referee's findings concerning claimant's exposure to asbestos or responsibility. (Ex. 151). Those portions of the order were affirmed by the Board. (Id. at 3). There was no further appeal.

In 1989, Dr. Edwards, pulmonary and internal medicine specialist, diagnosed claimant with asbestosis and pleural fibrosis, both of which Edwards attributed to prior exposure to asbestos. (Ex. 84-2).

A January 1990 Determination Order awarded claimant 46 percent unscheduled permanent disability. (Ex. 120-1). In June 1990, EBI denied responsibility "for any condition diagnosed as asbestosis," stating that it was "in receipt of medical opinion that [claimant] sustained a distinct and separate occupational disease diagnosed as asbestosis" and that this condition "did not arise out of and in the course and scope" of claimant's employment. (Ex. 130-1).

CONCLUSIONS OF LAW AND OPINION

Res Judicata

The Referee concluded that EBI was barred by claim preclusion from denying compensability and responsibility for claimant's asbestosis, finding that, under Referee Mongrain's order, EBI was liable

for claimant's "asbestos-related lung condition" and that asbestosis came under such a definition. Alternatively, the Referee concluded that claimant's "asbestosis condition was disabling on June 20, 1984 when EBI was on the risk."

EBI challenges both conclusions. First, it asserts that it is not barred by claim preclusion from denying claimant's asbestosis condition. Specifically, EBI contends that the asbestosis condition had not been diagnosed at the time of the 1987 order and that the order addressed only claimant's pleural fibrosis condition. Therefore, EBI maintains, the asbestosis condition has not been litigated and it is not precluded from denying the condition.

Res judicata is composed of two doctrines, claim preclusion and issue preclusion. Issue preclusion bars future litigation between the same parties concerning an issue that was "actually litigated and determined" in a setting where "its determination was essential to" the final decision reached. North Clackamas School Dist. v. White, 305 Or 48, 53, modified 305 Or 468 (1988). Claim preclusion, however, does not require actual litigation of an issue or that the determination of the issue be essential to the final decision reached. Rather, a claim is barred if it is based on the same factual transaction that was at issue in a prior action between the same parties. Drews v. EBI Companies, 310 Or 134, 140 (1990). Moreover, there must be a prior opportunity to litigate the claim, whether or not used, and there must be a final judgment. Id.

We conclude that EBI is not barred by issue preclusion from litigating claimant's asbestosis condition. Although parts of the 1987 order refer to claimant's "asbestos-related lung condition," when specifically discussing claimant's condition, the order refers only to the diagnosis of "pleural fibrosis" or "fibrosis of the lining of the lung." (Ex. 67-2). There is no reference in the order to "asbestosis" and, in fact, that separate and distinct condition was not diagnosed until 1989. We find that the 1987 order is most reasonably construed as being limited to claimant's pleural fibrosis condition and, therefore, the asbestosis condition was not actually litigated.

We further conclude that claim preclusion does not bar litigation of the asbestosis condition. The "factual transaction" at issue in the 1987 action concerned the date that claimant was disabled from his pleural fibrosis condition and which carrier was at risk on that date. (Ex. 67-1). The "factual transaction" here concerns claimant's disability from asbestosis. Moreover, because the diagnosis of asbestosis was not confirmed until 1989, there was no opportunity to litigate the condition. We therefore proceed to the merits.

Responsibility

Although EBI initially denied compensability of claimant's asbestosis, at hearing, the carriers, including EBI, agreed that responsibility was the only issue in dispute. (Tr. 9-10). EBI first contends that, under ORS 656.308(1), it may present evidence that employment conditions during its period of coverage could not have caused or contributed to claimant's asbestosis. EBI also asserts that the medical evidence proves that, contrary to the Referee's finding, claimant was not disabled by asbestosis in 1984 and that employment conditions during its period of coverage did not contribute or exacerbate claimant's asbestosis.

We recently held that ORS 656.308(1) does not apply in cases where there is no prior acceptance of a condition and a determination must be made concerning the assignment of initial liability for the condition between successive employers. See Fred A. Nutter, 44 Van Natta 854, 855 (1992). Instead, as we did before the enactment of ORS 656.308(1), we apply the last injurious exposure rule. Id. We therefore reject EBI's contention concerning the applicability of the statute in this case.

Under the last injurious exposure rule, if a worker proves that an occupational disease was caused by work conditions with successive employers, the potentially causal employer at the time disability occurs is assigned liability for the disease. Bracke v. Baza'r, 293 Or 239, 248 (1982); Runft v. SAIF, 303 Or 493, 499 n 2 (1987) (noting that the rule applies to cases in which an employer is successively insured by two or more carriers). If the claimant is not in potentially causal employment when disability occurs, the last such employer is liable. Id. The onset of disability is the date upon which the claimant first becomes disabled as a result of the compensable condition or, if the claimant

does not become disabled, the date he first seeks medical treatment for the condition. Progress Quarries v. Vaandering, 80 Or App 160, 162 (1986).

The medical evidence concerning claimant's asbestosis condition is provided by Dr. Edwards and Dr. Keppel, pulmonary and internal medicine specialists. Dr. Edwards first examined claimant in 1989 and diagnosed asbestosis. (Ex. 69A). In a subsequent deposition, Edwards stated that claimant "did have microscopic asbestosis in 1984, because a biopsy was done of his lungs by Dr. Overland which showed what I think they called nonspecific fibrosis." (Ex. 169-26). Edwards thought it "was impossible to say," however, whether or not claimant was experiencing symptoms in 1984 as a result of the asbestosis but that he did have such symptoms by 1989. (Id. at 27, 29-30).

Dr. Keppel reviewed the medical records for the 1987 litigation and for this action. Keppel reported that "in 1984 when pleural fibrosis was diagnosed asbestosis was not present." (Ex. 129-1). Keppel also found that the condition developed between 1984 and 1989. (Id. at 2). Keppel reiterated this opinion during a deposition, also stating that claimant's symptoms in 1984 were not attributable to asbestosis but that "the asbestosis that he had in 1989 did contribute to his impairment." (Ex. 171-16, 17).

Although the medical opinions indicate that claimant became symptomatic prior to 1989, the only definite date they can provide concerning claimant's disability due to asbestosis is the February 1989 examination by Dr. Edwards, when he found clinical evidence of such a condition. We therefore find that February 1989 is the date of disability for claimant's asbestosis since any other date would be speculative. Because claimant quit working in May 1988, he was not in a potentially causal employment when his disability occurred. We therefore assign liability to the last insurer on the risk when conditions existed that could have caused claimant's condition.

As provided above, the 1987 order found that claimant's last exposure to asbestos occurred in July 1987. At that time, Aetna was the carrier. Therefore, Aetna is presumptively responsible for claimant's asbestosis unless it establishes that conditions during an earlier carrier's coverage were the sole cause or that it was impossible for conditions during Aetna's coverage to have caused claimant's disease. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374 (1984).

We find that Aetna failed to carry its burden of proof necessary to shift responsibility to an earlier carrier. Dr. Edwards stated that, although the exposures to asbestos from 1976 through 1987 were "extremely unlikely" to have caused claimant's disease, it remained a "small possibility." (Ex. 169, 23-24). Dr. Keppel stated that "even the [asbestos] fibers that came in[to claimant's lungs] in 1987, the lung will have some small reaction to it," thereby contributing to the asbestosis. (Ex. 171-22, 23). We find that this evidence shows that it was not impossible that conditions during Aetna's coverage caused claimant's asbestosis. Therefore, responsibility remains with Aetna.

Finally, we note that the Referee awarded claimant's attorney an assessed fee of \$1,000, to be paid by EBI as the responsible carrier. Inasmuch as we have determined that Aetna is responsible for claimant's asbestosis condition, we modify the Referee's award to the extent that it is to be paid by Aetna rather than EBI. Moreover, we find that EBI's denial of claimant's asbestosis condition was not unreasonable and reverse the Referee's award of an attorney fee under ORS 656.382(1) on this basis.

ORDER

The Referee's order dated September 20, 1991 is reversed in part and modified in part. That portion which set aside EBI's denial is reversed. EBI's denial is reinstated and upheld. That portion which upheld Aetna's denial is reversed. Aetna's denial is set aside and the claim is remanded to it for processing according to law. We also reverse the Referee's attorney fee award under ORS 656.382(1). The Referee's \$1,000 attorney fee award shall be paid by Aetna rather than EBI.

In the Matter of the Compensation of
JACK A. GATES, Claimant
WCB Case No. 91-14362
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Brazeau.

Claimant requests review of Referee Black's order that declined to award an insurer-paid attorney fee for his attorney's efforts in obtaining additional temporary disability benefits. On review, the issue is attorney fees.

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

Claimant contends that his attorney is entitled to an insurer-paid attorney fee under ORS 656.386(1), which provides, in relevant part, that "[i]f an attorney is instrumental in obtaining compensation for a claimant and a hearing by a referee is not held, a reasonable attorney fee shall be allowed." This specific provision was added by the 1991 Legislature to overturn Jones v. OSCI, 107 Or App 78 (1991), which held that ORS 656.386(1) does not authorize an insurer-paid attorney fee when the insurer withdraws its denial of a claim for compensation before a hearing. See Jones v. OSCI, 108 Or App 230 (1991) (on reconsideration).

When the aforementioned provision is read in the context of the entire statute, as well as the legislative intent underlying its adoption, it is apparent that the provision was intended to apply in only those cases involving a denial of a claim for compensation. Within this context, a "denial of a claim for compensation" is a denial of the compensability of a condition or a medical service, not a denial concerning the amount of compensation to be paid. See James R. Jones, Jr., 42 Van Natta 238 (1990). See also Short v. SAIF, 305 Or 541, 545 (1988) (held that former ORS 656.386(1) is not applicable where the only compensation issue is the amount of compensation or the extent of disability, rather than whether the claimant's condition is compensable).

Inasmuch as the only compensation issue in this case involved the amount of temporary disability benefits to be paid, ORS 656.386(1) does not apply. Rather, the applicable attorney fee statute is ORS 656.386(2), which authorizes an out-of-compensation fee.

ORDER

The Referee's order dated March 11, 1992 is affirmed.

In the Matter of the Compensation of
JOHN A. GORDON, Claimant
WCB Case No. 90-18244
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Kevin Mannix, P.C., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of that portion of Referee Nichols' order that set aside its denial of claimant's aggravation claim for a low back condition. Claimant cross-requests review of that portion of the Referee's order that found that his low back injury claim was not prematurely closed. On review, the issues are premature closure, aggravation, 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

Premature Claim Closure

We adopt the Referee's "Conclusions of Law and Opinion" on the issue of premature claim closure with the following supplementation.

Claimant's assertion that his claim was prematurely closed by the May 1991 Determination Order is primarily based on his contention that he sustained a February 1991 "worsening" while participating in an authorized training program. Since this alleged "worsening" occurred while the claim was in open status and before claim closure, claimant need not prove an aggravation under ORS 656.273. Hallmark Fisheries v. Harvey, 100 Or App 657 (1990); Rodgers v. Weyerhaeuser Company, 88 Or App 458, 460 (1987). Rather, he need only establish his entitlement to temporary disability. Hallmark Fisheries v. Harvey, *supra*.

Inasmuch as his claim was already in open status and he was receiving temporary disability benefits during his involvement in the training program, claimant is not entitled to additional temporary disability. Nevertheless, if he can establish that his compensable condition was not medically stationary at the time of the May 1991 Determination Order, temporary disability benefits can be reinstated. In other words, claimant must prove that the aforementioned Determination Order was issued prematurely.

We agree with the Referee that claimant has failed to establish that his claim was prematurely closed. However, our conclusion is not based on the Referee's reasoning that claimant's condition became progressively worse since the incident at the authorized training program.¹ Instead, we base our determination on a consideration of claimant's condition as it existed at the time of claim closure and not on subsequent developments. See Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987); Alvarez v. GAB Business Services, 72 Or App 524 (1985).

In reaching such a determination, we do not find Dr. Melgard's June 1991 findings to be particularly persuasive concerning the question of whether claimant's compensable condition was medically stationary at the time the May 6, 1991 Determination Order issued. Rather, the record supports a conclusion that claimant's compensable condition was medically stationary when the claim was closed. Specifically, shortly after the September 1989 inception of claimant's authorized training program, Drs. Holmes and Orwick described his condition as medically stationary and stable. Despite periodic examinations for ongoing pain complaints, this description of claimant's condition was not contradicted until Dr. Melgard's June 1991 report. See Maarefi v. SAIF, 69 Or App 527, 531 (1984).

¹ For the reasons set forth in the "Aggravation" section of this order, we are not persuaded that claimant's condition worsened.

(The term "medically stationary" does not mean that there is no longer a need for continuing medical care.) Moreover, notwithstanding the alleged February 1991 incident, claimant did not seek medical treatment expressly related to the incident until approximately one month after the May 1991 Determination Order.

In light of these circumstances, we find that, at the time of the September 1990 and May 1991 Determination Orders, no further material improvement in claimant's compensable condition was reasonably expected from medical treatment or the passage of time. See ORS 656.005(17). Consequently, we hold that claimant's compensable condition was medically stationary and his claim was not prematurely closed.

Aggravation

The Referee concluded that claimant had proven a compensable aggravation. In doing so, the Referee found that claimant's current symptoms exceeded the waxing and waning of symptoms contemplated by claimant's last arrangement of compensation (a May 1991 Determination Order which did not award additional permanent disability beyond that granted by a May 1989 stipulation which increased claimant's unscheduled permanent disability award from 24 percent to 34 percent). We disagree.

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). To prove a worsened condition, claimant must show either a worsened underlying condition or increased symptoms resulting in a diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Leroy Frank, 43 Van Natta 1950 (1991); Edward D. Lucas, 41 Van Natta 2272 (1989) rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). If permanent disability has been previously awarded, claimant must establish that the worsening is more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award. ORS 656.273(8); Leroy Frank, supra.

Here, claimant's aggravation claim is based on Dr. Melgard's June 1991 reports. Inasmuch as the May 1991 Determination Order was the last closure order prior to claimant's request for claim reopening and since we have found that order to have properly closed the claim, claimant must establish that his low back condition worsened since the May 1991 Determination Order (the last award or arrangement of compensation).

Claimant consulted Dr. Melgard, neurosurgeon, complaining of leg pain, particularly on the left. Dr. Melgard had last examined claimant in October 1988. Noting reduced range of motion findings and diminished knee jerks, Dr. Melgard concluded that claimant required further diagnostic tests to determine what treatment method would be pursued. Dr. Melgard described claimant's condition as a "recent aggravation occurring in February of 1991." Acknowledging that he was unaware of claimant's prior award, Dr. Melgard determined that claimant was "currently disabled" and that his condition was not stationary.

The record is replete with references to similar examination findings and complaints since the January 1989 initial closure of his low back claim. Moreover, Dr. Orwick, claimant's then-attending physician, anticipated that claimant would continue to experience discomfort with activity.

We are not inclined to find that claimant's exacerbation resulted in diminished earning capacity since the most recent closure of his claim. In reaching this conclusion, we note that in stating that claimant was "currently disabled" Dr. Melgard conceded that he was "not privy to [claimant's] award regarding his back." Furthermore, Dr. Melgard did not conclude that claimant was totally disabled.

Under such circumstances, we question whether such a conclusory statement from Dr. Melgard is sufficient to establish that claimant's exacerbation has resulted in diminished earning capacity. In any event, even if we had found a diminution of claimant's earning capacity, we are not persuaded that (in light of his prior physician's references to continuing discomfort with activity) this exacerbation of symptoms exceeded the waxing and waning of symptoms contemplated by his previous 34 percent award.

Consequently, claimant has failed to establish a compensable aggravation. Accordingly, we reinstate the insurer's denial.

Extent of Disability

Finally, considering our conclusions regarding the premature closure and aggravation issues, it is appropriate to address the extent of claimant's permanent disability. Since we find the record sufficiently developed, we proceed with this determination without remand. See ORS 656.295(5).

Claimant contends that, although he failed to prove a worsening of his condition, he is entitled to a new determination of the extent of his disability because his vocational training program has now officially ended. He relies on ORS 656.268(5).

Under that statute, when a worker enters an authorized training program after an initial determination of disability is made, payment of permanent disability benefits ceases and payment of temporary compensation begins. See ORS 656.268(5). When the worker is no longer engaged in the training program, a redetermination of disability must be made unless the claimant's condition is not medically stationary. Id.

We agree with claimant that, under those circumstances, a worker is entitled to a new determination of his disability without regard to previous awards. Watkins v. Fred Meyer Inc., 79 Or App 521 (1986). Moreover, the worker need not show a worsening in his condition. Hanna v. SAIF, 65 Or App 649 (1983).

A January 4, 1989 Determination Order awarded claimant 24 percent unscheduled permanent disability for loss of range of motion in the low back. In May 1989, the parties stipulated to an additional award of 10 percent permanent disability for a total of 34 percent unscheduled permanent disability in regards to claimant's compensable low back injury. A subsequent Determination Order, dated September 5, 1990, awarded no additional compensation for permanent disability. Upon completion of a program of vocational training, a May 6, 1991 Determination Order awarded no additional compensation for permanent disability.

Claimant's condition became medically stationary on December 8, 1988 and his claim was closed by Determination Order on May 6, 1991. Thus, we apply the "standards" effective at the time of the Determination Order in rating claimant's permanent disability. Former OAR 436-35-001 et seq. WCD Admin. Order 6-1988. Former OAR 436-35-270 through 436-35-440 apply to the rating of claimant's unscheduled permanent disability.

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

Age and Education

Because claimant is 45 years of age, the age factor is given a value of 1. Former OAR 436-35-290(3).

The education factor consists of the elements of formal education, skills, and training. Claimant has a GED. Therefore, formal education has a value of 0. Former OAR 436-35-300(3). The value for skills is measured by reviewing the jobs claimant has successfully performed. Claimant's highest specific vocational pursuit (SVP) during the ten years prior to the date of hearing was 7 based upon his work as a drywall applicator (DOT 842.361-030). Therefore, the appropriate value for skills is 1. See former OAR 436-35-300(4). Finally, the training value is dependent upon whether or not claimant has documentation demonstrating competence in some SVP. Here, claimant has a certification of completion from a community college as a building inspector. Thus, the appropriate training value is 0. See former OAR 436-35-300(5)(a).

The sum of the age and education values is 2. See former OAR 436-35-280(4).

Adaptability

The adaptability factor for a claimant who is not working as a result of his compensable injury is determined by the claimant's residual physical capacity prior to the injury. Former OAR 436-35-310(4).

Here, claimant is not working as a result of his compensable injury and no offer of employment has been made. Claimant's physical capacity is in the medium/light category. Based on the above findings, we assign a value of 2.5 for the adaptability factor. See former OAR 436-35-310(3).

Impairment

In determining claimant's impairment, we rely on medical reports made after claimant was medically stationary and those containing the most complete measurements of range of motion closest to the hearing date. See William K. Porter, 44 Van Natta 937 (1992).

On June 3, 1991, Dr. Melgard reported that: "Examination reveals a very rigid back. Patient can bend forward about 10 degrees. Bending back about 2 degrees causes severe pain." (Ex. 48-2). Dr. Melgard does not provide any additional low back range of motion findings at that time. Further, on June 14, 1991, Dr. Melgard in a letter to claimant's attorney, referred to the June 3, 1991 range of motion findings and reported that: "I hope you understand how absolutely foolish this measurement is." (Ex. 50). Accordingly, we do not give these findings persuasive weight. See Bill J. Goodrich, 43 Van Natta 984 (1991) and Ruben D. Carlos, 43 Van Natta 605 (1991) (inconsistent range of motion findings fail to establish measurable impairment resulting from compensable injury).

An April 29, 1989 Western Medical Consultants medical report is the next medical evidence closest to the date of hearing after claimant became medically stationary which provides range of motion findings in regards to claimant's low back condition. Drs. Coletti, Jr. and Englander reported that: "All ranges of motion, flexion, extension, rotation, and lateral bending are 20 degrees, accomplished stiffly in a ratchet-type fashion." (Ex. 24-2). Drs. Coletti, Jr. and Englander further noted that: "It is not felt that he is operating purely from the standpoint of "functional overlay" and it is not felt that this is a motivating factor at this time" (Ex. 24-3).

Based on the foregoing facts, we find that Drs. Coletti, Jr. and Englander's report establishes that claimant had 20 degrees of flexion, which is rated at 7 percent impairment, 20 degrees of extension, which is rated at 2 percent, 20 degrees of right and left lateral bending, which is rated at 1 percent each, and 20 degrees of left and right rotation, which is rated at 1 percent each. These values are added for a total loss of range of motion value of 13 percent. Former OAR 436-35-350(18)-(21).

Computation of Unscheduled Permanent Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value, 1, is added to his education value, 1, the sum is 2. When that value is multiplied by claimant's adaptability value, 2.5, the product is 5. When that value is added to claimant's impairment value, 13, the result is 18 percent unscheduled permanent disability. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is therefore, 18 percent.

Either party may establish that the record, as a whole, constitutes clear and convincing evidence that the degree of permanent partial disability suffered by claimant is more or less than the entitlement indicated by the "standards." Former ORS 656.283(7) and 656.295(5). To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor, Inc. v. Tandy Corp., 303 Or 390 (1987).

Here, however, there is no evidence that claimant suffers permanent disability in excess of that awarded under the standards. Therefore, we do not find clear and convincing evidence that claimant suffers more than 18 percent unscheduled permanent disability.

Application of former ORS 656.214(5)

In Mary A. Vogelaar, 42 Van Natta 2846 (1990), we held that a worker is not entitled to be doubly compensated for a permanent loss of earning capacity which would have resulted from the injury in question, but which had already been produced by an earlier accident and compensated by a prior award. Mary A. Vogelaar, *supra*; See Thomason v. SAIF, 73 Or App 319, 322 (1985); Lawrence W. Scott, 40 Van Natta 1721 (1988). In cases where the claimant has prior unscheduled permanent disability, extent of permanent disability is determined by both an application of the standards and by consideration of any prior permanent disability awards. Mary A. Vogelaar, *supra*.

We proceed with our determination. Previously, claimant received 34 percent unscheduled permanent disability for her compensable 1987 low back injury. This award was calculated under the "guidelines."

Here, we have found that claimant is entitled to 18 percent unscheduled permanent disability under an application of the "standards." We have found that there is no clear and convincing evidence that claimant suffers more than that amount.

After consideration of claimant's prior award, we are not persuaded that claimant's permanent disability exceeds the 34 percent value previously awarded to claimant. See Ronald R. Buddenberg, 43 Van Natta 434 (1991), *aff'd* Buddenberg v. Southcoast Lumber, 112 Or App 148 (1992). Accordingly, we conclude that claimant is not entitled to additional unscheduled permanent disability for his back beyond his prior 34 percent award.

ORDER

The Referee's order dated September 13, 1991 is affirmed in part and reversed in part. That portion of the Referee's order that set aside the insurer's denial is reversed. The insurer's denial is reinstated and upheld. The assessed attorney fee in the amount of \$1,800 is also reversed. The September 1990 and May 1991 Determination Orders, which declined to grant claimant unscheduled permanent disability beyond his prior 34 percent (108.8 degrees) award, are affirmed. The remainder of the Referee's order is affirmed.

October 7, 1992

Cite as 44 Van Natta 2083 (1992)

In the Matter of the Compensation of
SHAWN M. McCULLOUGH, Claimant
WCB Case No. 91-14081
ORDER ON REVIEW
Whitehead, et al., Claimant Attorneys
Gail M. Gage (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Kinsley.

Claimant requests review of Referee Myzak's order which affirmed an Order on Reconsideration that awarded claimant no unscheduled permanent disability benefits for a low back injury, whereas a Notice of Closure awarded 13 percent (41.6 degrees) unscheduled permanent disability. The parties submitted the matter to the Referee on stipulated facts and written arguments. The sole issue on review is whether, upon a claimant's request for reconsideration of a Notice of Closure, the Director has authority to reduce the amount of permanent disability awarded in the Notice of Closure.

We affirm and adopt the Referee's order with the following modification. We find that the first sentence of ORS 656.268(5) pertains only to Determination Orders and not to Orders on Reconsideration. Therefore, we decline to find that the phrase "further compensation" is applicable in this case.

ORDER

The Referee's order dated February 21, 1992 is affirmed.

In the Matter of the Compensation of
RICHARD C. MORGANSTERN, Claimant
WCB Case No. 89-20808
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Brazeau.

Claimant requests review of Referee Herman's order which affirmed an Order on Reconsideration awarding 14 percent (44.8 degrees) unscheduled permanent disability for a low back injury. Claimant contends that the Director's temporary rules, WCD Admin. Orders 15-1990 and 20-1990, are invalid. On review, the issues are validity of the Director's rules, and extent of unscheduled permanent disability.

We affirm and adopt the Referee's order with the following supplementation. We recently held that the Board and its Hearings Division have no authority to declare invalid a rule promulgated by the Director. Eileen N. Ferguson, 44 Van Natta 1811 (1992). See also Edmunson v. Dept. of Insurance and Finance, 314 Or 291 (1992). In addition, we held that we must apply the applicable standards that were adopted by the Director. Id. The Referee did so here in affirming the Order on Reconsideration.

ORDER

The Referee's order dated February 20, 1992 is affirmed.

October 7, 1992

Cite as 44 Van Natta 2084 (1992)

In the Matter of the Compensation of
KAREN J. PERRY-WAGNER, Claimant
WCB Case Nos. 91-10050 & 91-09816
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerland.

Claimant requests review of those portions of Referee Neal's order that: (1) found that her claim for a right shoulder tendonitis condition was not prematurely closed; and (2) upheld the SAIF Corporation's denial of her aggravation claim for that condition. In her brief, claimant argues that the Referee erred in excluding a portion of her testimony. On review, the issues are evidence and premature closure or, alternatively, aggravation.

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

Claimant argues that the Referee erred in excluding her testimony concerning her September 1991 condition following a second alleged exacerbation. (See Tr. 24-5). In support, she contends that the disputed evidence should be admitted as relevant to the March 1991 aggravation claim. In this regard, claimant asserts that she suffered a worsening and an "unbroken chain" of symptoms extending from the work activities which caused her compensable right shoulder tendonitis to her current disability and need for treatment.

We review the Referee's evidentiary ruling for abuse of discretion. See ORS 656.283(7); James D. Brusseau II, 43 Van Natta 541 (1991).

Here, when claimant's counsel asked claimant how much worse she was in March 1991 than "at claim closure in September of 1990," (see Tr. 25), claimant responded as though she had been asked about periods prior to September 1991. (See Tr. 26). The Referee sustained SAIF's objection to

discussion of treatment after September 1991. (See Tr. 24-25). Considering claimant's apparent confusion, we find that the disputed evidence is so ambiguous that it would be unreliable even if it would otherwise be relevant and material. Consequently, we conclude that the Referee did not abuse her discretion by excluding the disputed portions of claimant's testimony.

ORDER

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

October 8, 1992

Cite as 44 Van Natta 2085 (1992)

In the Matter of the Compensation of
WALTER T. HEDSTROM, Claimant
WCB Case No. 91-05021
ORDER ON REVIEW
Coons & Cole, Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Brazeau, Kinsley and Hooton.

Claimant requests review of Referee T. Lavere Johnson's order that dismissed claimant's request for hearing due to lack of jurisdiction over the issue of claimant's request for authorization for a work hardening program. In his brief, claimant requests penalties and attorney fees for the insurer's allegedly unreasonable failure to process his claim for medical services. 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.

CONCLUSIONS OF LAW AND OPINION

The Referee found, *inter alia*, that the requested work hardening program is not a compensable medical service because it would be palliative and outside the statutory exceptions which allow palliative care after a worker becomes medically stationary. See ORS 656.245(1)(b). On review, claimant argues that the proposed treatment is at least partially curative and the insurer contends that it is wholly palliative.

We have held that "such a dispute generally concerns the effectiveness and appropriateness of the medical treatment at issue." Gladys M. Theodore, 44 Van Natta 905, 908 (1992); See also Leona J. Cunningham, 44 Van Natta 1078 (1992) (Jurisdiction over dispute concerning appropriateness of pain center treatment rests with Director). Therefore, original jurisdiction over this matter lies with the Director. See Id. Accordingly, we do not reach the merits.

ORDER

The Referee's order dated August 28, 1991 is affirmed.

Board Member Hooton dissenting.

This case comes to us from a request for hearing raising the issue of a *de facto* denial of medical services. The insurer received a request for authorization for certain medical services and failed to act in any respect. By dismissing this case on jurisdictional grounds the majority deprives this Board of the means of requiring compliance with the processing requirements of the statute. That result leaves the claimant subject to whatever game playing and delay the insurer chooses to impose on him in a particular claim. Because I cannot accept the notion that the insurer is granted an unbridled license to avoid the payment of legitimate expenses simply by refusing to act, I must dissent.

A de facto denial occurs when the insurer declines to pay or otherwise process a claim within 90 days of receipt. Barr v. EBI Companies, 88 Or App 132, 134 (1987). When a de facto denial occurs, claimant can request a hearing on the denial. The basis of the insurer's refusal to pay is unknown because no written denial stating the specific reasons for the insurer's disagreement has issued. Consequently, to establish his entitlement to compensation on a claim, claimant must establish every element of compensability. One of those elements is the causal relationship between the injurious event and the current specific claim for benefits.

In medical services cases we have declined to accept jurisdiction to determine whether the care is palliative or curative. Gladys M. Theodore, 44 Van Natta 905 (1992). We have also declined to accept jurisdiction to determine the reimbursability of expenses for palliative care, either originally or on review. Rexi L. Nicholson, 44 Van Natta 1546 (1992). We have also declined to accept jurisdiction to determine whether medical care is reasonable and necessary, or in violation of the Director's rules regarding medical services. Stanley Meyers, 43 Van Natta 2643 (1991). However, our refusal to accept jurisdiction in these cases does not mean we are, or should be, powerless to compel the proper processing of a claim for benefits.

We have accepted jurisdiction to determine whether a causal relationship exists between the original injury and the current claim for medical services. Michael A. Jaquay, 44 Van Natta 173 (1992). That is one of the elements that claimant must establish to obtain compensation for this de facto denied claim for medical services. Because we have jurisdiction to determine that element of the claim, we should establish it, rather than leave the parties to raise other issues concerning the claim before the Director and then return to the Hearings Division, if necessary, on this issue. It is before us; it can be decided; it should be decided. Only that portion of the claim over which the Referee legitimately has no jurisdiction should be dismissed.

The Referee found that the medical evidence supports a causal relationship between the compensable injury and the requested medical services. I agree. Therefore, I would find and conclude that there is a causal relationship between claimant's compensable injury and the requested service sufficient to support the claim.

The next question then is whether any action can be taken to require the insurer to properly process the claim. I conclude that there is. We are not able to award an attorney fee under ORS 656.386(1) because claimant has not yet finally prevailed on a rejected claim. We can however, award a penalty-related attorney fee under ORS 656.382(1), if the insurer's refusal to process is an unreasonable resistance to the payment of compensation.

While it is theoretically difficult to establish that there is an unreasonable resistance to the payment of compensation if no compensation is due or payable as the result of an order, the lack of compensation currently due is not dispositive of claimant's entitlement to a penalty-related attorney fee under ORS 656.382(1). If it were, we would be unable to assess a penalty for unreasonable refusal to authorize services, or to award a penalty-related attorney fee in cases of failure or refusal to disclose claims documents. To bridge this gap, and to give effect to the principles stated in ORS 656.382(1), a penalty-related attorney fee is appropriate in any case where the action, or inaction, of the insurer, is reasonably likely to result in a delay or reduction in compensation received. Morgan v. Stimson Lumber Company, 288 Or 595, mod 289 Or 93 (1980); Charles E. Condon, 44 Van Natta 726 (1992).

In support of a finding that the inaction of the insurer is reasonably likely to result in a delay or reduction in the benefits to which claimant is entitled, I note the provisions of OAR 436-10-041 applicable at the time the request for care was submitted to the insurer. That rule states, in pertinent part, as follows:

"(4) If 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." (Emphasis added.)

Because the majority prevents an efficient and expeditious resolution of the present claim, however, I can do naught but note that the majority requires the parties to establish the compensability of the medical service before the Director. Having submitted the present record, Opinion and Order,

and Order on Review together with a request that the Director issue an order consistent with the rule identified above, the Director will have no choice but to tell the insurer it must authorize and provide reimbursement for the proposed medical service. Thereafter, Director's order in hand, nothing in this order prevents claimant from returning to the Board, and its Hearings Division, to request attorney fees under ORS 656.386(1) and ORS 656.382(1). I, for one, would gladly grant them, frustrated only by the fact that the relief could have been provided at an earlier time.

October 8, 1992

Cite as 44 Van Natta 2087 (1992)

In the Matter of the Compensation of
RACHEL E. TORGESON, Claimant
 WCB Case Nos. 91-09823 & 91-11734
 ORDER ON RECONSIDERATION
 Westmoreland & Shebley, Claimant Attorneys
 Charles Lundeen, Defense Attorney
 Schwabe, et al., Defense Attorneys

K-Mart Corporation, a self-insured employer, requests reconsideration of our September 10, 1992 Order on Review, which found that claimant had sustained a new injury and concluded that K-Mart was responsible for her current low back condition. K-Mart contends that the medical evidence establishes that claimant merely suffered a mild aggravation of her prior injury and argues that Liberty Northwest Insurance Corporation remains responsible for the condition.

We withdraw our September 10, 1992 order. After a review of K-Mart's motion and supporting memorandum, we adhere to the conclusion that claimant sustained a new injury during her subsequent work exposure. Our order reflects the change in the test to shift responsibility required by ORS 656.308. Under prior case law, responsibility in this kind of case would shift only if a second incident materially contributed to a worsening of the underlying condition. Hensel Phelps Construction v. Mirich, 81 Or App 290 (1986). However, Under ORS 656.308, responsibility shifts if there is a new compensable injury involving the same condition. To prove a compensable injury, one need only show that there was an accidental injury at work that required medical services or resulted in disability. ORS 656.005(7)(a). The evidence in this case supports our finding that a new compensable injury occurred at K-Mart which resulted in the need for treatment and disability.

Accordingly, on reconsideration, we republish our September 10, 1992 order effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

October 9, 1992

Cite as 44 Van Natta 2087 (1992)

In the Matter of the Compensation of
JOHN M. FARRIS, Claimant
 WCB Case No. 91-09892
 ORDER ON REVIEW
 Richard Sly, Claimant Attorney
 Julene M. Quinn (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of those portions of Referee Peterson's order that: (1) increased claimant's unscheduled permanent partial disability (PPD) award for a low back injury from 13 percent (41.6 degrees), as determined by the Order on Reconsideration, to 16 percent (51.2 degrees); and (2) after offsetting two prior awards totaling 24 percent (76.8 degrees) for injuries to the same body part, affirmed the Order on Reconsideration to the extent that it awarded no additional PPD. In its brief, the SAIF Corporation challenges that portion of the order that increased

claimant's unscheduled permanent disability award to 16 percent. On review, the issue is extent of unscheduled permanent partial disability. We affirm.

FINDINGS OF FACT

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

The Determination Order issued November 28, 1990, finding claimant medically stationary on September 14, 1990, and awarding no additional PPD. The Order on Reconsideration issued July 18, 1991, increasing claimant's unscheduled PPD award, yet affirming the Determination Order to the extent that it awarded no additional PPD.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's conclusions and reasoning concerning the issue of extent of unscheduled PPD with the following comments.

Citing to former (temporary) OAR 436-35-007(3), the Referee concluded that claimant's prior PPD awards must be subtracted on a "degree for degree basis" from his current disability rating. On review, claimant argues that the rule impermissibly restricts ORS 656.222 and is, therefore, invalid. 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." Claimant asserts that because the statute "speaks" only in terms of the "past receipt of money," it does not contemplate a direct dollar for dollar or degree for degree or percentage for percentage offset by the dollars or degrees or percentages awarded in prior claims.

Subsequent to the Referee's order, we concluded that the phrase "past receipt of money" refers only to the claimant's previous award of temporary or permanent disability rather than providing a basis for offset. Gary R. Thomas, 44 Van Natta 1746 (1992). We concluded, therefore, that former OAR 438-35-007(3) does not conflict with ORS 656.222. Id. SAIF is entitled to offset on a degree for 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 further contends that the temporary rules, of which former OAR 436-35-007(3) was a part, were invalidly adopted and hence are unenforceable. Claimant did not raise this argument at hearing, and we decline to address his challenge on review. 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. Ferguson, supra. See also Edmunson v. Dept. of Insurance and Finance, 314 Or 291 (1992).

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.

In evaluating the extent of claimant's unscheduled PPD, the Referee correctly applied the appropriate disability standards in effect at the time of the issuance of the November 28, 1990 Determination Order. Accordingly, we affirm the Referee's order.

ORDER

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

In the Matter of the Compensation of
OMER LALLEY, Claimant
 WCB Case No. 91-07050
 ORDER ON REVIEW
 Pozzi, et al., Claimant Attorneys
 Cooney, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Spangler's order that affirmed an Order on Reconsideration awarding 20 percent (64 degrees) unscheduled permanent partial disability for a myocardial infarction. On review, the issue is extent of unscheduled permanent partial disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant has both a compensable myocardial infarction claim and preexisting coronary heart disease that was not caused or worsened by the myocardial infarction. Therefore, the Referee concluded that, because the standards require that impairment be due to work-related coronary heart disease and there was no evidence that claimant had any impairment due to his compensable injury, claimant was not entitled to an award of unscheduled permanent partial disability.

Claimant contends that the Referee "misinterpreted the standards." Claimant concedes that his preexisting coronary artery disease is not work-related. However, he asserts that "coronary heart disease" is defined by the standards "as one suffering from either a myocardial infarction or angina pectoris." Claimant maintains that he is entitled to unscheduled permanent disability because he suffered a myocardial infarction and satisfied every element required by former OAR 438-35-380(2).

Former OAR 436-35-380¹ provides in part:

"Impairments of the cardiovascular system shall be rated based on objective findings which establish that the job was the major contributor to: valvular heart disease, coronary heart disease, hypertensive cardiovascular disease, cardiomyopathies, pericardial disease, or cardiac arrhythmias. * * *

* * * * *

"(2) Impairment resulting from work related coronary heart disease shall be rated according to the following classifications:

* * * * *

"Class 2

"The worker has history of a myocardial infarction or angina pectoris that is documented by appropriate laboratory studies, but at the time of evaluation the worker has no symptoms while performing ordinary daily activities or even moderately heavy physical exertion[.]"

The term "coronary heart disease" is not defined by the standards. We find no basis, however, for defining the term in the manner asserted by claimant. Claimant apparently bases his definition on the requirement in Class 2 that the worker show a "history of a myocardial infarction or angina pectoris." There is no indication in the standards, however, for finding that the different classes also

¹ We note that the Referee and parties apparently applied the standards contained in WCD Administrative Order 2-1991. Inasmuch as those rules apply to claims closed on or after April 1, 1991, former OAR 436-35-003(1), and the Determination Order here issued before that date on January 23, 1991, we apply the standards provided in WCD Administrative Order 15-1990. However, our conclusion would be the same under either standards.

define the particular cardiac disease to be rated. Rather, each classification pertains only to rating impairment and, to this end, contains different requirements for various work-related cardiac diseases. If these differing requirements were used to define the cardiac disease at issue, it would unreasonably result in a different definition of a disease for each classification.

Moreover, as a practical matter, there is little basis for determining that a myocardial infarction constitutes coronary heart disease. As discussed by claimant's treating physician, the two conditions are not the same but require separate care and treatment. (See Ex. 44). Therefore, we interpret former OAR 438-35-380(2), Class 2, as requiring that a worker demonstrate impairment resulting from work-related coronary heart disease and a history of myocardial infarction or angina pectoris, as well as satisfy the remaining requirements in the rule. Because claimant's preexisting coronary heart disease was not work-related, he is not entitled to unscheduled permanent disability under former OAR 438-35-380(2). As the Referee noted, the insurer did not request a reduction in claimant's award at hearing or on review, and therefore we affirm the 20 percent award provided by the Order on Reconsideration.

Finally, because we have based our conclusion on the ground discussed above, we do not address the Referee's alternative holding that claimant returned to regular work because his current employment is "substantially the same job held at the time of injury," see former OAR 436-35-270(3)(a), and therefore is not entitled to any value for age, education, or adaptability.

ORDER

The Referee's order dated October 1, 1991 is affirmed.

October 9, 1992

Cite as 44 Van Natta 2090 (1992)

In the Matter of the Compensation of
TERRIE G. PALUMBO, Claimant
 WCB Case No. 91-05784
 ORDER ON REVIEW
 Schneider & Denorch, Claimant Attorneys
 Roberts, et al., Defense Attorneys

Reviewed by Board Members Hooton and Brazeau.

Claimant requests review of those portions of Referee Bethlahmy's order which: (1) declined to calculate her temporary total benefits to include her total pre-injury wages; and (2) dismissed her hearing request on the issue of rate of scheduled permanent disability for lack of jurisdiction. In its brief, the insurer contends that the Referee incorrectly directed it to pay temporary total disability benefits up to April 30, 1991, the date of closure. Further, the insurer contends it is entitled to an immediate offset against the procedural temporary disability benefits granted by the Referee's order, rather than against claimant's future permanent disability awards, as provided for in the order. Finally, the insurer also contends that the Referee erred in calculating a penalty based upon amounts which include the overpayment of benefits. On review, the issues are temporary total disability, jurisdiction, entitlement to offset, and penalties and attorney fees. We reverse in part and affirm in part.

Temporary Total Disability

The Referee found that although claimant was medically stationary as of January 18, 1991, her claim was not closed until April 29, 1991. The Referee, therefore, concluded that claimant remained procedurally entitled to temporary disability benefits until claim closure. We disagree.

Substantively, a worker's entitlement to temporary disability benefits ends on the medically stationary date. Because of delays in processing, the actual payment of temporary disability benefits continues until the Determination Order is issued. That delay may result in an overpayment of temporary disability benefits that an employer is entitled to recoup by deduction from any permanent disability compensation awarded. ORS 656.268(10). However, if the processing delay does not result in an overpayment, the Board has no authority to impose one. See Lebanon Plywood v. Seiber, 113 Or

App 651 (1992). Therefore, we conclude that claimant is only entitled to temporary disability benefits until January 18, 1991, the date at which claimant was medically stationary.

In light of this conclusion, it follows that the insurer's penalty assessment for unreasonable claim processing shall not include temporary disability payable between January 19, 1991 through April 29, 1991.

Since no temporary disability is due for that period, no penalty is likewise assessable. In calculating the rate of claimant's temporary disability benefits, the Referee declined to include her wages from another job. We agree.

In Bolton v. Oregonian Publishing Co., 93 Or App 289 (1988), the court held that employers do not have to bear more than the "cost" of the injuries sustained in their service. See also Reed v. SAIF, 63 Or App 1 (1983). Further, employers cannot be required to pay greater benefits for temporary disability than the maximum benefits that would be due on the basis of wages that a claimant was receiving in their employ. Therefore, the fact that a claimant had other employment cannot enhance an employer's liability. See Bolton, *supra* at 293. Accordingly, here, we find that claimant's benefits should be determined solely on the basis of the wages that she earned performing maintenance and management work for the Guardian Management Corporation. *Id.*; see also Liberty Northwest v. Church, 106 Or App 477 (1991); Patricia A. Washbish, 40 Van Natta 2032 (1988).

Jurisdiction - Rate of Scheduled Permanent Partial Disability

We affirm and adopt the Referee on this issue. See Charlene J. Erspamer, 44 Van Natta 1214 (1992).

Entitlement to Offset

Inasmuch as we have reversed the procedural temporary disability benefits granted by the Referee, the issue of offset is moot.

ORDER

The Referee's order dated September 6, 1991, as amended and reconsidered October 3, 1991, is reversed in part and affirmed in part. Those portions of the order that awarded claimant temporary disability benefits from January 19, 1991 through April 29, 1991, and assessed a penalty based on that compensation are reversed. The attorney fee in the amount of 25 percent of the increase in compensation is reversed. The remainder of the order is affirmed.

October 9, 1992

Cite as 44 Van Natta 2091 (1992)

In the Matter of the Compensation of
TIMOTHY W. REINTZELL, Claimant
WCB Case No. 91-06946
ORDER ON RECONSIDERATION
Max Rae, Claimant Attorney
David O. Horne, Defense Attorney

On August 27, 1992, we withdrew our July 28, 1992 order, which had: (1) increased claimant's scheduled permanent disability award for the left arm from 11 percent to 25 percent; and (2) directed the insurer to pay claimant's scheduled permanent disability award at a rate of \$305 per degree. We took this action to await consideration of the parties' proposed stipulation.

The parties have submitted a proposed "Stipulation and Order," which 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 there is a final court determination in SAIF v. Herron, 114 Or App 64 (1992) providing that awards such as claimant's shall be paid at a rate of \$305 per degree. The parties further stipulate that "the Board's order is otherwise affirmed."

Pursuant to the stipulation, the parties agree that this matter shall be dismissed with prejudice. We have approved the parties' stipulation, thereby fully and finally resolving this dispute. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

October 9, 1992

Cite as 44 Van Natta 2092 (1992)

In the Matter of the Compensation of
KENNETH L. THOMPSON, Claimant
WCB Case No. 91-07007
ORDER ON RECONSIDERATION
Black, et al., Claimant Attorneys
David Schieber (Saif), Defense Attorney

On September 11, 1992, we withdrew our August 20, 1992 Order on Review for reconsideration. In our August 20, 1992 order, we reversed a Referee's award of scheduled permanent disability for a loss of grip strength. Furthermore, our order reinstated a Notice of Closure award of 26 percent (12.48 degrees) scheduled permanent disability for the left thumb.

Our September 11, 1992 abatement order was issued in response to claimant's request for reconsideration. Specifically, claimant argues that he has established entitlement to an award for loss of grip strength. Claimant also contends that our order did not consider the Referee's other impairment awards in finding claimant's total scheduled permanent disability to be 26 percent. In withdrawing our order, we granted the SAIF Corporation an opportunity to respond. As SAIF has not responded within 14 days from the date of our order, we proceed with our reconsideration.

On reconsideration, claimant first argues that "common sense" dictates that an amputation of the tip of the thumb has nothing to do with lost grip strength. Claimant argues that the "only explanation left" is that nerve damage or atrophy must be responsible for his loss of grip strength.

We agree with claimant that nerve damage or atrophy would be a basis for a grip strength award. See former OAR 436-35-110(3)(a). However, as we explained in our Order on Review, claimant has pointed to no medical evidence on the record to support such a finding. Without such evidence, we decline to make an award based upon the inference argued by claimant.

Claimant next argues that, because we affirmed the Order on Reconsideration, our order did not take the Referee's impairment findings of sensory loss and loss of amputation into account. We agree that; on review, SAIF did not contest claimant's entitlement to an award for sensory loss and loss due to amputation of the left thumb. Moreover, we agree with the Referee's increased award based upon 20 percent for claimant's amputation, which combines with the 18 percent impairment value for sensory loss, for a total of 34 percent scheduled permanent disability. Therefore, on reconsideration, we find that claimant's total scheduled permanent disability award to date is 34 percent (16.32 degrees) scheduled permanent disability for loss of use or function of the left thumb.

Consequently, in lieu of the Referee's award and in addition to the Notice of Closure award of 26 percent (12.48 degrees) scheduled permanent disability for the left thumb, claimant is awarded 8 percent (3.84 degrees) for a total award of 34 percent (16.32 degrees). In lieu of the Referee's attorney fee award, claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed \$2,800.

Accordingly, on reconsideration, as modified herein, we adhere to and republish our August 20, 1992 Order on Review. 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
EDNA M. ANDERSON, Claimant
WCB Case Nos. 91-10490 & 91-02402
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
David R. Fowler (Saif), Defense Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The self-insured employer requests review of Referee Baker's order that: (1) set aside its denial of claimant's aggravation claim for her current bilateral upper extremity condition; (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition; (3) found that claimant's proposed right carpal tunnel surgery was reasonable and necessary; and (4) awarded an assessed attorney fee of \$3,000. On review, the issues are compensability, responsibility, medical services and amount of attorney fees. We vacate in part, modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of the Referee's finding regarding claimant's proposed surgery.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we first address the self-insured employer's contention that its acceptance of December 11, 1987 was limited to claimant's hand, and any other conditions (i.e., elbow and shoulder) must be established as a new claim.

Here, the employer's acceptance was phrased as an acceptance of claimant's "over use syndrom" (sic). Furthermore, prior medical reports reference both claimant's bilateral hand and arm problems. The reports also refer to claimant's discomfort up into the right shoulder area. Finally, it was noted that claimant had a "positive Tinel's sign at the right cubital tunnel of the elbow." See Exs. 6, 7, 9A.

Under the circumstances, we do not find that claimant's original accepted claim was specifically limited to her right hand. Accordingly, we find that the Referee properly addressed the compensability and responsibility of claimant's bilateral upper extremity condition.

Compensability

The Referee found that there were no objective findings to support a new injury during claimant's subsequent employment. Additionally, he declined to rely on the opinion of claimant's treating doctor and former treating chiropractor as those opinions were inconsistent with their prior reports. Accordingly, the Referee concluded that claimant had failed to establish either a "new injury" or an occupational disease with SAIF's insured.

On review, the self-insured employer argues that if claimant failed to establish objective findings, she has also failed to establish compensability of an aggravation claim. At the outset, we conclude that the record contains medical evidence supported by objective findings.

On June 10, 1988, Dr. Clifford reported that claimant had complaints of pain, in addition to marked weakness and paresthesia of the right upper extremity. Dr. Clifford also noted that a June 9, 1988 follow-up examination illustrated "persistent tenderness of the right wrist and elbow...." Additionally, a September 24, 1990 physical therapy report requested by Dr. Ellison noted a mild decrease in range of motion on the right, with grip and pinch strength substantially less on the right than on the left. We have previously found that such reports constitute medical evidence supported by objective findings. See Suzanne Robertson, 43 Van Natta 1505 (1991); also see Georgia-Pacific v. Ferrer, 114 Or App 471 (1992). We, therefore, disagree with the employer's argument that claimant has not proven such findings.

We also reject the employer's contention that, if claimant has proven any objective findings,

such findings will automatically be evidence of a new injury or occupational disease. We find that a final determination of that issue is dependent on an examination of the medical evidence, rather than speculation regarding the temporal aspect of a case. Accordingly, we address the issue of compensability of claimant's claim, either as a new injury or occupational disease, or as an aggravation.

Although claimant has established objective findings, we nonetheless agree with the Referee that she has failed to prove compensability of a new injury or occupational disease claim with the second employer. Like the Referee, we base our conclusion on the fact that claimant's treating doctor and former chiropractor changed their opinions without explanation. Moreover, Dr. Ellison's October 8, 1991 concurrence refers to claimant's work for SAIF's insured as the major cause of her increased symptomatology, not the underlying pathology. (Ex. 39).

We next determine whether claimant has established compensability of her claim for aggravation. In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the compensable condition. ORS 656.273(1); Perry v. SAIF, 307 Or 654 (1989). To prove a compensable worsening of her scheduled condition, claimant must show that she is more disabled; i.e., that she has sustained an increased loss of use or function of that body part, either temporarily or permanently, since the last arrangement of compensation. International Paper Co. v. Turner, 304 Or 354 (1987), on rem 91 Or App 91 (1988).

Here, at the time of the May 20, 1988 Determination Order, claimant was working without restrictions or limitations and her condition was asymptomatic. However, in August 1990, claimant had pain, numbness and swelling in both hands and wrists. Claimant's hands went to sleep while she was working on the production line. Finally, carpal tunnel surgery was recommended by claimant's doctors.

Accordingly, we find that claimant has established an increased loss of use or function. Moreover, although we decline to rely on the inconsistent reports of claimant's treating doctors, the remaining evidence supports a finding that claimant's current condition is materially related to the compensable condition. (Ex. 32, 33H, 37).

We, therefore, find that claimant has proven that her condition has worsened since the last arrangement of compensation, which was the May 20, 1988 Determination Order that awarded temporary disability. In addition, we also find that claimant's aggravation claim has been established by medical evidence supported by objective findings. Accordingly, claimant has proven compensability of her claim for aggravation.

Responsibility

In cases in which an accepted injury is followed by an increase in disability during employment with a later carrier, responsibility presumptively rests with the original carrier, unless the claimant sustains an actual, independent compensable injury or occupational disease during the subsequent work exposure. ORS 656.308(1); Ricardo Vasquez, 43 Van Natta 1678 (1991); Donald C. Moon, 43 Van Natta 2595 (1991). Thus, as the last carrier against which claimant had an accepted overuse condition, the employer remains responsible unless it establishes that claimant's work activities with SAIF's insured were the major contributing cause of a pathological worsening of claimant's bilateral upper extremity condition. See Rodney H. Gabel, 43 Van Natta 2662 (1991).

We have above found that the doctors' opinions regarding a new occupational disease or a new injury with the subsequent employer are not persuasive. There is no other medical evidence to support a new injury or occupational disease. Accordingly, for that same reason, we find that the self-insured employer has failed to establish that claimant sustained an actual new injury or occupational disease with SAIF's insured. Therefore, we agree with the Referee that, pursuant to ORS 656.308(1), responsibility remains with the self-insured employer.

Proposed surgery

The Referee concluded that claimant's proposed carpal tunnel surgery was reasonable and necessary. He therefore directed the employer to accept claimant's medical services claim for right carpal tunnel surgery.

Subsequent to the Referee's order, we concluded that, in cases involving an insurer's contention that proposed surgery is excessive, inappropriate or ineffectual, original jurisdiction is no longer shared by the Director and the Hearings Division. Stanley Meyers, 43 Van Natta 264 (1991). Rather, because such disputes do not constitute matters concerning a claim, original jurisdiction lies exclusively with the Director. ORS 656.704(3); Stanley Meyers, *supra*. Furthermore, we have also held that disputes regarding proposed medical services, as well as those regarding current medical services, are within the Director's original jurisdiction pursuant to ORS 656.327. Kevin S. Keller, 44 Van Natta 225 (1992).

Accordingly, inasmuch as the employer's denial of proposed surgery did not raise a matter concerning a claim within the jurisdiction of the Hearings Division, we vacate that portion of the Referee's order and dismiss claimant's hearing request on that issue.

Amount of attorney fee

The Referee awarded claimant's counsel an assessed attorney fee of \$3,000 for services at hearing. On review, the employer contends that the Referee's fee should be reduced because he found that claimant had failed to establish objective findings to support her claim.

We do not find the Referee's attorney fee to be excessive even considering the fact that he found that claimant had not proven objective findings to support a new injury or occupational disease claim. However, claimant has conceded that a portion of the attorney fee awarded by the Referee was for her counsel's efforts on the issue of proposed carpal tunnel surgery. Accordingly, because we have vacated the Referee on that issue, we also vacate a portion of the attorney fee.

After reviewing the record and considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that \$500 is representative of the portion of the total attorney fee awarded by the Referee in conjunction with the issue of medical services. Therefore, we vacate that portion of the Referee's attorney fee award. The Referee's attorney fee award is accordingly modified to \$2,500.

Attorney fee/Board review

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that \$900 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. We note that no attorney fee is available for those portions of claimant's respondent's brief devoted to the issues of medical services and attorney fees.

ORDER

The Referee's order dated November 18, 1991, as reconsidered January 6, 1992, is vacated in part, modified in part and affirmed in part. That portion of the Referee's order that set aside the self-insured employer's denial of claimant's proposed surgery is vacated. Claimant's request for hearing on that issue is dismissed. That portion of the Referee's attorney fee award, which we have determined to be \$500, that was awarded in conjunction with the issue of proposed surgery is also vacated. The Referee's attorney fee award is modified to \$2,500. The remainder of the Referee's order is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of \$900, to be paid by National Fruit Canning Company.

In the Matter of the Compensation of
DOUGLAS R. ROBINSON, Claimant
WCB Case No. 91-06687
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
David Horne, Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Mongrain's order that upheld the insurer's "de facto" denial of claimant's aggravation claim for a back injury. 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 Referee concluded that claimant failed to establish a compensable aggravation claim. Because we agree with that conclusion, we do not address the insurer's alternative argument regarding the effect of the Board's prior Own Motion Determination.

With regard to the merits of the aggravation claim, we adopt the Referee's conclusions, subject to the following supplementation.

On review, claimant contends that the Referee improperly focused on the lack of any time loss as determinative of claimant's aggravation claim. Rather, claimant argues, the determinative inquiry is whether claimant is less able to work in the broad field of general occupations.

We agree that claimant is not required to establish that he is less able to work in his present occupation to establish a compensable aggravation. Smith v. SAIF, 302 Or 396, 401 (1986). However, we conclude (as we believe the Referee also concluded) that claimant has failed to establish a general reduction in his ability to work. Our review of the medical record in particular persuades us that claimant has exhibited more-or-less unchanged objective physical findings throughout his claim. (Compare Ex. 5 with Exs. 17, 22 and 29). Moreover, we are not persuaded that the various spinal abnormalities noted by Dr. Dubois in April 1988 are causally related to the compensable lumbosacral strain accepted by the insurer. Therefore, we affirm the Referee's order which upheld the insurer's "de facto" denial.

ORDER

The Referee's order dated October 25, 1991, as reconsidered November 19, 1991, is affirmed.

In the Matter of the Compensation of
CARL R. ALATALO, Claimant
WCB Case No. 91-12629
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Brazeau.

Claimant requests review of that portion of Referee Livesley's order which: (1) affirmed an Order on Reconsideration without consideration of a medical arbiters report; and (2) denied claimant's motion to remand an Order on Reconsideration to the Department of Insurance and Finance (DIF). In his appellant's brief, claimant argues that the Order on Reconsideration is invalid because he objected to the impairment findings and DIF failed to appoint a medical arbiter. On review, the issues are the validity of DIF's Order on Reconsideration and remand. We vacate.

FINDINGS OF FACT

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

On July 3, 1991, claimant requested reconsideration of the January 15, 1991 Determination Order, as amended by a January 18, 1991 Determination Order. His request for reconsideration included a letter and a form provided by DIF.

Claimant's letter noted that the Determination Order award was based on Dr. Thompson's independent medical examiner's report, contested "the amount" of scheduled and unscheduled permanent disability, and requested appointment of a "medical panel" to review the claim.

On the form supplied by DIF, claimant checked the box which stated that he disagreed with the "[i]mpairment findings by the attending physician at the time of claim closure."

On August 29, 1991, an Order on Reconsideration issued which affirmed the Determination Order in all respects. The order acknowledged that claimant had disputed the impairment findings used to close the claim and explained that, although the Determination Order was affirmed, a medical arbiter review would be scheduled.

CONCLUSIONS OF LAW AND OPINION

Validity of Department's Order

Prior to hearing, claimant requested that the Order on Reconsideration be remanded to DIF for the appointment of a medical arbiter. The Referee denied claimant's motion to remand and affirmed the Order on Reconsideration which affirmed the Determination Order. On review, claimant argues that the Order on Reconsideration is invalid because DIF failed to appoint a medical arbiter as required by statute. We agree.

Claimant became medically stationary after July 1, 1990. Therefore, the 1990 amendments to the Workers' Compensation Act apply to this case. See Oregon Laws 1990 (Special Session), ch. 2 §54(3). Additionally, the Director's rules in effect at the time of the January 18, 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).

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 (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, the self-insured employer contends that claimant's request for reconsideration was insufficient to contest the impairment findings. We disagree. We find that, on the form supplied by DIF, claimant indicated that he contested the impairment findings used in rating his disability by checking "Yes" on box number 4. (Ex. 60B). Moreover, while his letter indicated that he was contesting "the amount" of permanent disability, it also noted that the impairment findings were based on Dr. Thompson's report and requested appointment of an arbiter. (Ex. 60A). Under these circumstances, we find that claimant contested the medical findings of impairment and brought into play the medical arbiter process. However, in this case, although the Order on Reconsideration noted that a medical arbiter review would be scheduled (Ex. 62), it issued before the medical arbiter's findings had been submitted 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. Consequently, we conclude that, because the Director did not comply with the mandatory procedure set forth in ORS 656.268(7) and claimant objects to the order issued, the Order on Reconsideration is invalid. See id. Accordingly, the Referee lacked jurisdiction to consider claimant's request for hearing and we vacate his order.

Remand

In vacating the Referee's order, we note that claimant argues that the Referee abused his discretion in failing to remand this claim to DIF and also requests that we remand this matter to DIF for further proceedings consistent with ORS 656.268(7). However, neither the Referee nor the Board is authorized to "remand" the case to DIF. 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 DIF. 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 January 17, 1992 is vacated. Claimant's request for hearing is dismissed for lack of jurisdiction.

October 14, 1992

Cite as 44 Van Natta 2098 (1992)

In the Matter of the Compensation of
LAMARR H. BARBER, Claimant
WCB Case No. 91-10157
ORDER ON REVIEW
Philip Schuster II, Claimant Attorney
Norman Cole (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Kinsley.

The SAIF Corporation requests review of Referee Crumme's order that: (1) found that the Hearings Division had jurisdiction to consider claimant's medical services claim for a ramp at his home; and (2) set aside its denial of the same claim. Claimant cross-requests review and contends that SAIF should be assessed penalties and attorney fees for allegedly unreasonable resistance to the payment of compensation and that SAIF has waived its right to deny the claim by its failure to request Director's review. On review, the issues are jurisdiction, penalties and attorney fees and waiver. We vacate.

FINDINGS OF FACT

On May 26, 1988, claimant suffered a low back strain at work. SAIF accepted the claim generated by the injury. (Ex. 3).

On September 27, 1989, claimant underwent a laminectomy and diskectomy at L4-5. (Ex. 4). Following surgery, claimant began using a rolling "walker" device or cane for walking. Claimant's home is not easily accessible with a cane or walker. He has, therefore, requested that SAIF provide a ramp for the entrance of his home. He has also asked for a cart or wheelchair.

On July 17, 1991, SAIF denied claimant's requests. Claimant thereafter requested a hearing. At hearing, claimant withdrew his request for a cart or wheelchair, but continued to assert entitlement to a ramp for his home. That issue, therefore, was litigated at hearing on October 29, 1991.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The Referee concluded that the ramp requested by claimant constituted reasonable and necessary medical services resulting from claimant's compensable injury. He, therefore, set aside SAIF's denial. We conclude, however, that the Referee lacked subject matter jurisdiction over the issue raised.

The Hearings Division has original jurisdiction over matters concerning a claim. See ORS 656.704(3). However, the 1990 Legislature restricted that 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 Stanley Meyers, 43 Van Natta 2463 (1991) we held that under ORS 656.704(3) "matters concerning a claim," do not include any dispute regarding medical treatment that is challenged on one of the grounds listed in ORS 656.327(1), *i.e.*, treatment that is "excessive, inappropriate, ineffectual, or in violation of rules regarding the performance of medical services."

Moreover, in Mark L. Hadley, 44 Van Natta 690 (1992), we found that "medical services" and "medical treatment" have identical meanings for purposes of ORS 656.327(1) and 656.704(3). "Medical services" include medical, surgical, hospital, nursing, ambulances and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services. ORS 656.245(1)(c); see OAR 436-10-005(24). "Medical services" also include the removal of architectural barriers. See Stoddard v. Credit-Thrift Corp., 103 Or App 283 (1990).

We conclude from the facts before us that the Referee lacked jurisdiction to consider claimant's request for an architectural alteration of his home. Rather, the Director has exclusive original jurisdiction over this matter. We, therefore, vacate the Referee's order. We further note that until the Director issues an order, SAIF may not issue a denial of medical services on any of the grounds listed in ORS 656.327(1). Any such denial is void as a matter of law. See Stanley Meyers, *supra*.

Inasmuch as we have concluded that the Referee lacked jurisdiction over this matter, we do not reach the issue of waiver and equitable estoppel. Further, as the penalty issue is contingent on the resolution of the medical service dispute, neither do we reach that issue.

ORDER

The Referee's order dated November 27, 1991 is vacated. Claimant's hearing request is dismissed for lack of subject matter jurisdiction.

In the Matter of the Compensation of
PAMELA S. CHENEY, Claimant
WCB Case No. 91-10153
ORDER ON REVIEW
Deich & Meece, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Hooton and Brazeau.

Claimant requests review of that portion of Referee Leahy's order that declined to enforce the award of an attorney fee by a prior order. In her brief, she also raises the issue of the Referee's failure to address the scope of the SAIF Corporation's claim acceptance. On review, the issues are the enforcement of a prior order awarding an attorney fee and the scope of acceptance. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact as supplemented herein.

For the first paragraph on page 2, we substitute the following. Claimant filed a claim for an injury to her knee and back on July 20, 1990.

On October 15, 1990, SAIF denied claimant's wrenched knee and back strain.

On July 9, 1991, SAIF issued a formal acceptance of claimant's herniated disc at L4-5.

By Order on Review dated June 11, 1992, the Board vacated that portion of the prior referee's order which found that claimant's herniated discs were compensable and affirmed that portion of the order which found that claimant's right ankle pain and low back strain were compensable. This order has become final.

By continuing to assert the compensability of claimant's L4-5 disc condition, claimant's counsel was instrumental in obtaining compensation for claimant without a hearing.

CONCLUSIONS OF LAW AND OPINION

Claimant presents three arguments on review. First, she contends that SAIF unconditionally accepted the claim by means of the July 9, 1991 Stipulation and Order. Second, she contends that SAIF's July 9, 1991 Notice of Claim Acceptance is an unconditional acceptance of her July 1990 claim. Third, she contends that the Referee erred in not enforcing the prior referee's order by requiring SAIF to pay the attorney fee awarded therein.

Scope of Stipulation and Order

Claimant argues that SAIF unconditionally accepted the claim when it entered into the July 9, 1991 Stipulation and Order. Claimant bases her argument on the language of the stipulation by which the parties agree to settle "all issues raised or raisable at this time," which she interprets as precluding SAIF from limiting its acceptance.

This language restricts from future litigation only those issues that were ripe for litigation at the time of the stipulation. Here, at the time of the Stipulation, there was no issue raised bearing on the acceptance. The acceptance, which was issued by a SAIF claims adjuster, was dated the same day as the Stipulation. There is no evidence linking it to the Stipulation. The Stipulation specifies that the prior referee's order that set aside the denial was being appealed and that claimant had filed a request for hearing raising issues including late payment of temporary disability, penalties and fees. Accordingly, the Stipulation consisted only of an agreement for the payment of temporary disability compensation and penalties and attorney fees and cannot be construed to operate as an unconditional acceptance of claimant's claim or to preclude SAIF from continuing to litigate compensability.

Scope of Acceptance

Claimant contends that, by issuing a formal, written acceptance rather than notifying her by means other than a formal acceptance that payments of temporary disability were being paid pursuant to ORS 656.313(1)(A), SAIF unconditionally accepted her claim. SAIF maintains that it accepted claimant's "back condition" only because it was ordered to do so by the prior referee and that, therefore, the Referee was correct in not addressing the acceptance issue. We analyze the issue as follows.

An acceptance is limited to specified conditions. ORS 656.262(6)(a); Johnson v. Spectra Physics, 303 Or 49 (1987). If, as here, SAIF specifically accepted in writing only one of several conditions encompassed by a single claim, it has not specifically accepted the other conditions allegedly related to the accepted part of the claim. Id. at 56. Therefore, even if SAIF issued a formal, specific acceptance in response to a referee's order, such circumstances do not operate to expand the acceptance to include unspecified conditions, absent an acceptance of symptoms of an underlying disease. Johnson v. Spectra Physics, supra; cf. Georgia Pacific v. Piowowar, 305 Or 494 (1988).

We are, however, unaware of any claims processing rule that would require an insurer to issue a formal acceptance in response to an appealed order. See OAR 436-60-000 et seq. When an Opinion and Order issues which sets aside a denial of compensability, the insurer must pay certain benefits consistent with the requirements of ORS 656.313(1). However, if the insurer challenges the Opinion and Order by a request for Board review, it is continuing to assert that the claim is not compensable. Under those circumstances, an acceptance which meets the requirements of ORS 656.262 is inconsistent with the assertion of noncompensability, and is not required by ORS 656.313(1). The mere payment of compensation pursuant to the processing requirements established by ORS 656.313(1) does not constitute the acceptance of a claim. Johnson v. Spectra Physics, supra, ORS 656.262(9). A Notice of Acceptance, however, issued pursuant to ORS 656.262(6) can only be set aside with the issuance of an appropriate "back up" denial in which the insurer bears the burden of proving noncompensability by clear and convincing evidence. ORS 656.262(6).

SAIF argues that the Board has already established that an Acceptance issued pursuant to an Opinion and Order is not final and is subject to the final outcome on review of the claim. It cites Linda R. Myers, 43 Van Natta 1188 (1991). We disagree.

In Linda R. Myers, supra, the majority specifically declined to consider the argument raised by SAIF here based on its agreement that the claim was compensable on the merits. Consequently, we conclude that SAIF has formally accepted a claim limited to the condition specified, i.e., claimant's herniated disc at L4-5.

Enforcement of Attorney Fee Awarded by Prior Order

The Referee found that there was no factual evidence on the attorney fee question and did not address the issue further, effectively denying claimant's request for enforcement. We agree with the outcome, in part, but for different reasons.

In all cases involving accidental injuries where a claimant finally prevails in a hearing before the referee or in a review by the board, a reasonable attorney fee shall be allowed. ORS 656.386(1)(emphasis added).

Here, claimant was awarded an attorney fee at hearing by a prior referee's order for prevailing on the issue of compensability. (Ex. 5). This order was timely appealed by SAIF. At the time of the Referee's order, the appeal was still pending. Because the statute does not require that the attorney fee be paid pending appeal, enforcement of that portion of the prior order awarding claimant an attorney fee was properly denied. ORS 656.386(1); Loren Callihan, 41 Van Natta 1449 (1989).

Attorney Fee for SAIF's Acceptance of L4-5 condition

Although we have found that the Referee properly denied claimant's request to enforce the attorney fee awarded in the prior order, we have found that SAIF did accept a herniated disc at L4-5. That acceptance finally determines the compensability of the condition specified. Based on claimant's

attorney's efforts in asserting the compensability of claimant's L4-5 disc condition, we conclude that claimant's attorney was instrumental in obtaining compensation for claimant without a hearing by obtaining SAIF's acceptance. ORS 656.386(1).

We therefore find that claimant is entitled to an assessed fee for obtaining the acceptance of the specified condition. Considering the factors specified in OAR 438-15-010(4) and especially considering the time devoted to the issue, (as indicated by the record) and the value of the interest involved, we award a reasonable assessed attorney fee in the amount of \$400 to be paid directly to claimant's attorney in addition to and not out of any compensation made payable by this award.

ORDER

The Referee's order dated November 21, 1991 is modified. Claimant is awarded an assessed attorney fee in the amount of \$400 pursuant to ORS 656.386(1), to be paid by SAIF, for services in obtaining the acceptance of the herniated L4-5 disc condition.

October 14, 1992

Cite as 44 Van Natta 2102 (1992)

In the Matter of the Compensation of
DEBRA L. COOKSEY, Claimant
 WCB Case No. 91-12830
 ORDER ON REVIEW
 Pozzi, et al., Claimant Attorneys
 VavRosky, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of Referee Crumme's order that: (1) increased claimant's unscheduled permanent disability award from 14 percent (44.8 degrees), as awarded by Determination Order, to 25 percent (80 degrees) unscheduled permanent disability for her low back condition; (2) awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of her right leg, whereas a Determination Order had awarded no scheduled permanent disability; and (3) directed that claimant's scheduled permanent disability award be paid at the rate of \$305 per degree. On review, the issues are extent of scheduled and unscheduled permanent disability and rate of scheduled disability. We modify in part, reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Extent

On review, the employer disagrees with the Referee's application of the "standards." The Referee apparently relied upon claimant's argument that the temporary standards, 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), were invalid because the Director violated the required rulemaking procedures in promulgating that set of standards.

We have recently addressed the issue of validity of the temporary standards. In Eileen N. Ferguson, 44 Van Natta 1811 (1992), we declined to address a claimant's challenge to the validity of the temporary rules. We concluded that we were without statutory authority to rule on the validity of another agency's administrative rules and we declined to find the Director's temporary standards invalid. Ferguson, supra.

In the present case, we agree with the employer that the extent of claimant's disability is properly evaluated pursuant to the temporary rules in effect at the time of the October 10, 1991 Determination Order.

Unscheduled permanent disability

On review, the only value disputed by the employer is that of impairment. We, therefore, adopt the Referee's reasoning and his assigned values for age, education and adaptability.

The employer first disagrees with the Referee's award of impairment values for claimant's unoperated disc derangement and for her chronic condition limiting repetitive use of the low back where claimant's other impairment exceeded 5 percent. We agree with the employer that the temporary rules in effect at the time of the Determination Order did not provide for impairment values for either the unoperated disc derangement or a chronic condition award where claimant's impairment exceeded 5 percent. See former OAR 436-35-320(5)(a). Accordingly, under the applicable standards, claimant is not entitled to values for such impairment.

The employer also argues that the Referee improperly awarded claimant separate awards of 5 percent each for claimant's initial and repeat laminectomy and discectomy procedures at L5-S1. The employer disagrees with the case cited by the Referee that provided for a 5 percent award for each surgery where the claimant had two L4-5 laminectomies with discectomies. See Karen J. Demaris, 43 Van Natta 1028 (1991).

We agree with the Referee's application of the Demaris case. Former OAR 436-35-350(2) provides for an award of 5 percent for a laminectomy with single discectomy. We find no language in that provision that limits the award to the original surgery. Moreover, we find no other rules that would impose such a limitation.

Claimant's impairment values under the standards, therefore, are 5 percent for loss of range of motion, 5 percent for the initial laminectomy and discectomy at L5-S1, and 5 percent for the repeat laminectomy and discectomy at L5-S1. Claimant's impairment values are combined for a total value of 14.

To compute claimant's permanent disability under the standards, claimant's stipulated value for age plus education, multiplied by adaptability is 4. That value is added to her impairment value, 14, for a total of 18 percent unscheduled permanent disability. Former OAR 436-35-280(7). Claimant's unscheduled permanent disability under the "standards" is, therefore, 18 percent.

Scheduled permanent disability

The employer contends that the Referee erred by awarding claimant scheduled permanent disability for her right leg condition, as the medical arbiter did not find that claimant had a chronic condition limiting repetitive use. The employer concedes that there is evidence from claimant's treating doctors to support such an award, but the employer argues that the arbiter's findings must be followed.

We agree with the Referee that claimant is entitled to an award of 5 percent for her chronic condition. ORS 656.268(7) does not mandate that only the medical arbiter's findings be considered in evaluating claimant's impairment. Timothy W. Reintzell, 44 Van Natta 1534 (1992). Rather, ORS 656.726(3)(f)(B) provides that under the standards, "impairment is established by a preponderance of medical evidence based upon objective findings." Therefore, claimant's impairment is established by the preponderance of medical evidence, considering the medical arbiter's findings and any prior impairment findings. Reintzell, supra.

Accordingly, we disagree with the employer that the Referee erred by relying upon the findings of claimant's treating physicians, rather than the arbiter, in awarding an impairment value for scheduled permanent disability. We, therefore, adopt the Referee on the issue of extent of scheduled disability.

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. 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).

Claimant is entitled to a carrier-paid attorney fee for successfully defending against the employer's request for a reduction of her award of scheduled permanent disability. We note that claimant is not entitled to an attorney fee for those portions of the brief devoted to the issues of unscheduled permanent disability and rate of scheduled disability. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable attorney fee for claimant's counsel's services on review concerning the issue of extent of scheduled permanent disability is \$400, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by that portion of claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 27, 1992 is modified in part, reversed in part and affirmed in part. That portion of the Referee's order that increased claimant's unscheduled permanent disability award to 25 percent is modified. In lieu of the Referee's award, and in addition to the Determination Order award, claimant is awarded 4 percent (12.8 degrees) for a total award to date of 18 percent (57.6 degrees) unscheduled permanent disability for her low back condition. In lieu of the Referee's attorney fee award, claimant's attorney is awarded 25 percent of this increased compensation, not to exceed \$2,800. 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 award at the rate in effect at the time of the injury. The remainder of the Referee's order is affirmed. For prevailing over the employer's request for review on the issue of extent of scheduled permanent disability, claimant's counsel is awarded \$400, to be paid by the employer.

October 14, 1992

Cite as 44 Van Natta 2104 (1992)

In the Matter of the Compensation of
FRANK P. HEATON, Claimant
WCB Case No. 91-07715
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation, on behalf of the noncomplying employer, requests review of those portions of Referee Lipton's order that: (1) set aside its partial denial of claimant's low back condition; and (2) awarded claimant an assessed attorney fee for prevailing on the denied claim. 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

On review, SAIF contends that claimant has failed to establish compensability of his low back condition as a consequential condition. We disagree.

Under ORS 656.005(7)(a)(A), no injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition. Albany General Hospital v. Gasperino, 113 Or App 411 (1992). In the present case, we find, and both parties agree, that claimant's low back condition is properly analyzed as a consequential condition, rather than as a condition directly resulting from the industrial accident. Accordingly, claimant must prove that his compensable right leg injury is the major contributing cause of his low back condition.

SAIF argues that the opinion of Dr. Pearson, claimant's treating physician, is not persuasive. SAIF contends that Dr. Pearson changed his opinion without explanation and did not obtain a complete history from claimant. SAIF argues that the Referee should have relied upon the opinion of Dr. Fuller, independent medical examiner. We disagree.

On March 26, 1991, Dr. Pearson noted that claimant continued to experience the low back pain he had reported on March 6, 1991. Dr. Pearson reported that the back pain could be explained "in light of the difference in walking angles caused by favoring the right leg causing a strain in the lower back."

On April 23, 1991, Dr. Kayser, IME, reported that claimant did have a lumbar back problem. He stated that the etiology was unclear and a relationship had not been established between the back problem and the injury. He concluded his report by suggesting that claimant return to Dr. Pearson for consideration of back care.

On May 3, 1991, Dr. Pearson stated that he concurred with Dr. Kayser's report "about the back problem."

SAIF argues that Dr. Pearson's subsequent opinion in August 1991, that claimant's back condition was indirectly caused by the leg injury and his use of crutches and subsequent limping, is contrary to his concurrence with Dr. Kayser's opinion that the etiology of the back problem was unclear. We disagree. We do not find that Dr. Pearson's statement that the etiology of claimant's problem was unclear in May 1991 undermines his subsequent opinion in August 1991 that claimant's back problem was attributable to the compensable leg injury. Furthermore, we do not find the earlier and later reports of Dr. Pearson to be inconsistent or unpersuasive due to his final conclusion that the origin of claimant's low back problem could be determined.

SAIF next contends that Dr. Pearson's report is not complete as he did not have a history of claimant's 1983 back injury. We agree with the Referee that it is not apparent from the record that Dr. Pearson had either an inaccurate or incomplete history. Moreover, the record establishes that claimant's 1983 injury resolved without residuals. Under the circumstances, we agree with the Referee that Dr. Pearson's report is persuasive.

Finally, SAIF argues that the Referee should have relied upon the opinion of Dr. Fuller, IME, who reported that claimant had inconsistencies in his examination. Dr. Fuller also concluded that any back condition claimant had stemmed from his obesity and was also related to preexisting strains noted in the early 1980's.

We agree with claimant that Dr. Fuller's opinion is not persuasive. Of the numerous doctors that examined claimant, Dr. Fuller is the only doctor who found claimant's exams to be inconsistent. Additionally, as claimant notes, Dr. Fuller has not explained how obesity and the 1983 strain could have caused claimant's current back conditions if claimant had not experienced low back symptoms for several years, prior to the time of the compensable injury. Furthermore, we conclude that the opinion of Dr. Pearson, claimant's treating physician, should be relied upon as Dr. Pearson has had the opportunity to observe claimant over an extended period of time, including during the onset of his back symptoms, and has treated him for both the compensable injury and the consequential condition.

We agree with the Referee that claimant has established that his compensable leg injury is the major contributing cause of his consequential low back condition. The low back condition is, therefore, compensable.

Attorney fees

SAIF contends that claimant failed to assert entitlement to a carrier-paid attorney fee at the time of hearing. SAIF argues that the Referee's subsequent attorney fee award on reconsideration was improper. We disagree.

At hearing, compensability of claimant's low back condition was raised by claimant, and SAIF denied that the low back condition was a compensable consequential condition. (Tr. 9). Accordingly, claimant is entitled to an assessed fee for prevailing over SAIF's denial. See ORS 656.386(1); Richelle E. Volz, 43 Van Natta 902 (1991). Moreover, in light of claimant's statutory entitlement to an assessed fee, we conclude that an attorney fee is a natural derivative from a compensability determination regarding a represented claimant and the fact that the Referee may have neglected to award an attorney fee in his initial order does not preclude the Referee from later making such an award on reconsideration.

Claimant is entitled to an assessed attorney fee for successfully defending against SAIF's request for review on the compensability issue. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services on Board review is \$1,000, to be paid by SAIF on behalf of the noncomplying employer. In reaching this conclusion, we have particularly considered the complexity of the issue, the time devoted to the case (as represented by claimant's respondent's brief) and the value of the interest involved. We note that no attorney fee may be awarded for that portion of claimant's brief devoted to the issue of attorney fees. Dotson v. Bohemia, Inc., 80 Or App (1986).

ORDER

The Referee's order dated January 31, 1992, as reconsidered by the February 12, 1992 order, is affirmed. For services on review, claimant's counsel is awarded a reasonable assessed fee of \$1,000, to be paid by the SAIF Corporation on behalf of the noncomplying employer.

October 14, 1992

Cite as 44 Van Natta 2106 (1992)

In the Matter of the Compensation of
ROBERT J. HUGHES, Claimant

WCB Case Nos. 90-00535 & 89-17295

ORDER ON REMAND

Pozzi, Wilson, et al., Claimant Attorneys

David L. Runner (Saif), Defense Attorney

Cooney, Moscato, et al., Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Electric Mutual Liability Insurance Co. v. Automax, 113 Or App 531 (1992). The court has reversed our prior order, Robert J. Hughes, 43 Van Natta 875 (1991), which held Electric Mutual responsible for claimant's bilateral carpal tunnel syndrome (CTS) because it had accepted the condition when it previously accepted his claim for a right shoulder and arm strain. Because we neglected to make any finding regarding whether claimant's accepted right shoulder and arm strain was a symptom of, or caused by, his bilateral CTS, the court has remanded for reconsideration.

On remand, we enter the following order in place of our previous order.

FINDINGS OF FACT

Claimant worked as an auto detailer for Portland Auto Auction (Portland) and Automax from early 1987 through June 1989. On November 11 and 12, 1988, while working for Portland, claimant worked approximately 37 hours buffing cars. The next day, he sought medical treatment from Dr. Browning for severe right shoulder and arm pain. Browning diagnosed a right shoulder and arm strain, authorized time loss, and prescribed physical therapy. Claimant filed a claim seeking benefits for his right arm condition, including symptoms of swelling and numbness. Electric Mutual, which provided coverage for Portland, accepted the claim with an general letter of acceptance.

Claimant returned to his work for Portland on November 18, 1988 and continued work there until April 1989, when he quit because of pain, numbness and tingling in both shoulders and arms. After a week or so off work, claimant's symptoms decreased and he began performing similar work at a less demanding pace for Automax on April 17, 1989. Within a short time, his symptoms returned. Claimant was referred to Dr. Hill, a neurosurgeon, who ordered nerve conduction studies and diagnosed bilateral CTS, right worse than left.

On June 18, 1989, Dr. Hill requested authorization to perform bilateral carpal tunnel surgery. Electric Mutual denied the request and suggested that claimant file a new injury claim with Automax, which he did. SAIF, which provided coverage for Automax, also denied the claim. Claimant requested a hearing on both denials.

CONCLUSIONS OF LAW AND OPINION

The issue presented is which carrier, Electric Mutual or SAIF, is responsible for claimant's bilateral CTS. The Referee found that claimant's work for either carrier could have caused the condition and, applying the last injurious exposure rule, assigned responsibility to SAIF. In our original order, we concluded that Electric Mutual had accepted responsibility for claimant's bilateral CTS when it accepted his November 1988 claim for a right shoulder and arm strain. Citing SAIF v. Abbott, 103 Or App 49 (1990), on recon 107 Or App 53 (1991), we reasoned that Electric Mutual's acceptance of the prior claim involving right arm numbness and swelling also encompassed the disease causing those symptoms.

After further consideration of this matter, we conclude that our reliance on SAIF v. Abbott, supra, was misplaced. In that case, the injury was described as involving swelling, aching and hand numbness. In its original opinion, the court found that those symptoms were caused by CTS and, therefore, held that the insurer's specific acceptance of the symptoms constituted an acceptance of the condition producing those symptoms. Although this case is factually similar, there is no evidence that claimant's accepted right shoulder and arm strain was a symptom of, or caused by his bilateral CTS. The medical record reveals only that claimant had suffered from CTS symptoms since 1987. That fact, in our opinion, is insufficient to support a finding that Electric Mutual had accepted the bilateral condition when it accepted claimant's right shoulder and arm strain.

Nonetheless, we conclude that Electric Mutual is fully responsible for claimant's condition. At hearing, both Electric Mutual and SAIF conceded that claimant's work activity as an auto detailer caused his bilateral CTS. In such a case, liability is assigned to the insurer on risk at the time the disease results in disability. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984); Bracke v. Baza'r, 293 Or 239 (1982).

Claimant first experienced symptoms suggestive of CTS in November 1987. In April 1989, while working for Electric Mutual's insured, claimant left work due to those symptoms, i.e., forearm pain, numbness, cramping and tingling. Claimant testified, and we find as fact, that his symptoms at that time affected both shoulders, and extended down his forearms to his hands and fingers. He explained that his work load had increased and that he was no longer able to perform his work because of his symptoms. Moreover, claimant's testimony in this regard is un rebutted, and supported by the medical reports of Dr. Hill, the treating physician.

Under those facts, we conclude that Electric Mutual is responsible for claimant's bilateral CTS, because it had provided coverage during the last potentially causal employment before claimant's disability. The fact that bilateral CTS was not actually diagnosed until after claimant had worked for Automax does not, in our opinion, alter this conclusion. Application of the last injurious exposure rule depends on when a claimant is disabled by a disease, not on when the disease is first correctly diagnosed.

Thus, Electric Mutual is responsible under the last injurious exposure rule. In order to shift responsibility, it must show that claimant's later employment independently contributed to a pathological worsening of the condition. Spurlock v. International Paper Company, 89 Or App 461 (1988). After our review of the record, we conclude that Electric Mutual has failed to carry that burden. The only expert medical opinion introduced in this matter came from Dr. Hill, who opined that only claimant's symptoms had worsened during his work for SAIF's insured.

ORDER

The Referee's order dated April 20, 1990 is reversed. Electric Mutual's responsibility denial for claimant's bilateral CTS is set aside, and the claim is remanded to Electric Mutual for further processing accordingly to law. SAIF's responsibility denial for the same condition is reinstated and upheld. Electric Mutual is responsible for the \$1,650 attorney fee awarded to claimant's counsel by the Referee.

October 14, 1992

Cite as 44 Van Natta 2108 (1992)

In the Matter of the Compensation of
LARRY R. RUECKER, Claimant
WCB Case No. 91-10313
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Jerome Larkin (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Thye's order which upheld the SAIF Corporation's denial of claimant's aggravation claim for a right shoulder condition. On review, the issue is aggravation.

We affirm and adopt the Referee's order, except for his determination that claimant's last award or arrangement of compensation was an aggravation denial dated January 10, 1991. Instead, we find that claimant must prove a worsening resulting in diminished earning capacity since the date of the final opportunity to present evidence, which was a May 12, 1989 Stipulation Order. See Frank L. Stevens, 44 Van Natta 60 (1992); Joseph Klinsky, 35 Van Natta 332, aff'd mem., 66 Or App (1983).

ORDER

The Referee's order dated February 25, 1992 is affirmed.

In the Matter of the Compensation of
FLOARE TAUT, Claimant
WCB Case No. 91-12790
ORDER ON REVIEW (REMANDING)
Welch, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of that portion of Referee Lipton's order that upheld the insurer's denial of claimant's occupational disease claim for carpal tunnel syndrome. Claimant also moves the Board to remand this matter for consideration of additional evidence. On review, the issues are remand and compensability. We remand.

Following filing of her request for review, claimant filed a motion asking the Board to remand the matter to the Referee for consideration of additional evidence. Having deferred ruling on the motion until the time of review, we now address claimant's motion.

We have no authority to consider evidence not already included in the record. Under ORS 656.295(5), our only statutory power is to remand the case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See Bailey v. SAIF, 296 Or 41, 45 n 3 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988) (approving applicability of Compton v. Weyerhaeuser Co., supra, to remand by the Board).

In this case, Dr. Brett, claimant's treating physician, was the only physician to diagnose claimant with carpal tunnel syndrome; two independent medical examinations (IME) and claimant's former treating physician all opined that they could not establish that claimant suffered from such a condition. Rejecting the opinion of Dr. Brett, the Referee found that claimant did not prove the compensability of her claim.

Following the Referee's order, Dr. Brett performed right and left carpal tunnel releases. Claimant now seeks remand on the basis of Dr. Brett's operative findings of "severe compression of a very edematous and erythematous right medial nerve" and "tight compression of edematous and erythematous [left] median nerve." In response, the insurer has submitted a supplemental memorandum containing a report from Dr. Button, one of the physicians who conducted an IME, stating that, because no abnormalities were revealed by EMG/NCS tests prior to surgery, there was a "major discrepancy between the repeated EMG/NCS and the surgeon's perception of the operative findings."

We conclude that claimant has established a compelling reason warranting remand in order to admit the operative reports. The evidence concerns claimant's disability and, because surgery did not take place until after the hearing, it was not available at the time of hearing. Furthermore, we find that the evidence is reasonably likely to affect the outcome of the case, because it goes directly to the question of whether claimant has a bilateral carpal tunnel syndrome. Therefore, we remand to the Referee for the admission of additional evidence regarding claimant's post-hearing surgeries. In addition, the Referee shall allow the insurer an opportunity to cross-examine or rebut this late-produced evidence. The submission of this additional evidence shall be made in any manner that the Referee determines will achieve substantial justice.

Accordingly, the Referee's order is vacated. This matter is remanded to Referee Lipton for further proceedings consistent with this order. Following these further proceedings, the Referee shall issue a final, appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
PHON VEOPRADITH, Claimant
WCB Case No. 91-05537
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Miller, Nash, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The self-insured employer requests review of Referee Leahy's order that: (1) set aside its denial of claimant back injury claim; and (2) awarded claimant's attorney an assessed fee of \$2,000. On review, the issues are compensability and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee analyzed compensability of the claim under ORS 656.005(7)(a)(B), finding that claimant had proved that a material contributing cause of his need for treatment from January 17, 1991 through April 22, 1991 was his work activities and, therefore, he was entitled to benefits for that period. The employer disputes this conclusion, first asserting that our order in Bahman N. Nazari, 43 Van Natta 2368 (1991), misconstrues ORS 656.005(7)(a)(B) and, second, that claimant did not prove compensability under ORS 656.005(7)(a)(B) because his preexisting condition was at all times the major contributing cause of his need for treatment.

As the employer notes, our order in Nazari is now on appeal to the Court of Appeals. We decline to reexamine our analysis in that order, leaving that task to the Court of Appeals.

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, supra. 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.

The record consists of three opinions regarding causation. In an independent medical examination, Drs. Reimer, neurologist, and Fuller, orthopedic surgeon, reported that claimant had "degenerative changes L2-3, L3-4, L4-5" that preexisted a January 1991 work incident. (Ex. 36-4). The report further found that the January 1991 injury "was a recurrent strain" and that, as of April 15, 1991, claimant had completely recovered from this condition. (Id.). In an addendum, Dr. Reimer stated that claimant's "apparent need for treatment in [1991] was secondary to preexisting problems that may have been aggravated by a lumbar strain. It appears that the major contributing cause for his need for treatment was preexisting and not related to the injury in question." (Ex. 42).

Dr. Reimer was later deposed. He stated that claimant had sustained a back strain as a result of the January 1991 work incident, (ex. 44-6), and that this strain required treatment, (id. at 8). However, Dr. Reimer further stated that the strain combined with claimant's preexisting degenerative disc disease, and that the preexisting condition was the major contributing cause of his need for treatment. (Id. at 11, 14).

Dr. Azhar, M.D., claimant's treating physician, initially disagreed with the report of Drs. Reimer and Fuller. (Ex. 43). However, Dr. Azhar later concurred with a letter drafted by the insurer's counsel clarifying that he disagreed with the report only to the extent that claimant's work should be modified.

(Ex. 45-1). Dr. Azhar indicated that he did not disagree with the diagnosis or findings in the report or addendum and agreed that claimant's "degenerative joint disease was the major contributing cause of his complaints and need for treatment [] in 1991[.]" (Id).

Finally, Dr. Berkeley, neurological surgeon, who examined claimant on February 22, 1991 and subsequently reviewed the medical records, concurred with a letter drafted by the employer's counsel. That letter stated that "the major contributing cause of [claimant's] complaints in 1991 and need for medical treatment was his underlying degenerative disc disease. * * * You also believe the 1991 event at Epson was a material but not major contributing cause of [claimant's] complaints and need for treatment at that time. * * * Therefore, with respect to the lumbar strain diagnosis, you believe the 1991 incident was a material contributing cause, but the underlying degenerative disc disease was the major contributing cause of this diagnosis and treatment." (Ex. 44-2).

We find that the medical evidence is in agreement that, as a result of a January 1991 work incident, claimant sustained a back strain. Therefore, we affirm the Referee's order to the extent that claimant proved a compensable injury. However, we further find that the strain combined with a preexisting degenerative disc disease and that, although the injury was a material cause of his need for treatment, his preexisting condition was the major contributing cause during his entire need for treatment during 1991. Consequently, we modify the Referee's order to the extent that he found claimant's need for treatment from January 1991 through April 22, 1991 to be compensable. Instead, we find these treatments relate to claimant's noncompensable preexisting condition. We note parenthetically, however, that claimant is not precluded from proving that any future disability and/or need for treatment is related, in major part, to the compensable injury and, therefore, compensable.

Attorney Fees

The employer also asserts that, if the Board finds that the major contributing cause of claimant's need for treatment was his preexisting condition, then we should reduce the \$2,000 attorney fee awarded by the Referee. We agree. We have modified the Referee's order to the extent that claimant's need for treatment in 1991 is compensable. Furthermore, in view of the factors set forth in OAR 438-15-010(4), we find that a reasonable fee for services at hearing is \$1,500, to be paid by the employer.

Claimant is entitled to an attorney fee for services on Board review concerning the compensability of claimant's injury claim. After considering the factors set forth in OAR 439-5-010(4), we find that a reasonable fee is \$150, to be paid by the employer. 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 October 28, 1991 is modified in part and affirmed in part. The self-insured employer is not responsible for claimant's need for treatment from January 1991 through April 1991. In lieu of the Referee's \$2,000 attorney fee award, claimant's attorney is awarded \$1,500, to be paid by the self-insured employer. The remainder of the order is affirmed. For services on Board review concerning the compensability of claimant's injury claim, claimant's attorney is awarded \$150, to be paid by the employer.

In the Matter of the Compensation of
RICHARD B. WORTHEY, Claimant
WCB Case No. 91-10211
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Kathryn Alvey (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Brazeau.

Claimant requests review of Referee Spangler's order that dismissed claimant's request for hearing for lack of jurisdiction. On review, the issue is jurisdiction. We affirm.

FINDINGS OF FACT

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

As of the date that claimant filed his request for hearing, the Director had not issued an order in response to SAIF's request for review of Dr. Misko's request for authorization of surgery.

CONCLUSIONS OF LAW AND OPINION

Dr. Misko requested authorization from SAIF for surgery. After SAIF failed to respond, claimant filed a request for hearing, asserting that SAIF had "de facto" denied his request for surgery. SAIF then requested the Director to review the request for surgery. The Director issued a Notice of Required Action on a Treatment Plan containing instructions to the parties for resolution of the dispute. The notice did not approve or disapprove of the proposed surgery and, as of the date of hearing, the Director had not yet issued such an order.

The Referee concluded that he lacked jurisdiction to consider claimant's request for hearing, finding that the Director had original jurisdiction to address the issue of whether or not the proposed surgery was appropriate under ORS 656.327(1). We agree.

ORS 656.327(1)(a) provides that if an injured worker, insurer, or self-insured employer "believes that an injured worker is receiving medical treatment that is excessive, inappropriate, ineffectual or in violation of the rules * * * and wishes review of the treatment by the director," those parties may so notify the Director. Subsequent to the Referee's order, we interpreted ORS 656.327(1)(a), along with ORS 656.327(2) and 656.704(3), as vesting original jurisdiction of disputes concerning medical treatment that allegedly is "excessive, inappropriate, ineffectual or in violation of rules" exclusively with the Director. See Stanley Meyers, 43 Van Natta 2643, 2645 (1991). Furthermore, "a worker may not request a hearing on any issue that is subject to the jurisdiction of the director under [ORS 656.327] until the director issues an order under [ORS 656.327(2)]." ORS 656.327(1)(c).

Claimant argues that, because the disputed surgery here is proposed and ORS 656.327(1)(a) refers to medical services that an injured worker "is receiving", ORS 656.327 is inapplicable. We rejected this argument in Kevin S. Keller, 44 Van Natta 225, 228-29 (1992), holding that the statute was equally applicable to proposed medical services.

Therefore, because the dispute at issue here concerns the appropriateness of the proposed surgery, the Director has original jurisdiction of this matter. Furthermore, the Director having taken jurisdiction following SAIF's request for review by the Director, claimant may not file a request for hearing until the Director issues an order under ORS 656.327(2). Because no such order had issued prior to claimant's request for hearing in this case, jurisdiction remained with the Director. Therefore, the Referee correctly dismissed claimant's request for hearing.

Finally, we note that claimant attached to his brief a transcript of his treating physician's deposition. This document was not offered, nor admitted, at hearing. In light of our conclusion that the Referee correctly dismissed claimant's hearing request, we need not consider whether the transcript is admissible. In any event, we would decline to exercise our authority to remand this case for consideration of the transcript. See ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n 3 (1983).

ORDER

The Referee's order dated November 15, 1991 is affirmed.

October 15, 1992

Cite as 44 Van Natta 2113 (1992)

In the Matter of the Compensation of
JANICE S. BROWN, Claimant
WCB Case No. 91-07341
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Kinsley.

Claimant requests review of Referee Gruber's order that upheld the SAIF Corporation's denials of: (1) claimant's low back injury claim; and (2) claimant's occupational disease claim for a low back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

FINDINGS OF ULTIMATE FACT

The April 4, 1991 incident was not a material contributing cause of claimant's disability or need for treatment.

Claimant's subsequent work activities were not the major cause of a worsening of her 1979 and 1982 underlying condition that resulted in disability or the need for treatment.

Claimant's work activities since the 1982 low back injury caused periodic low back and leg symptoms for which she required medical services.

CONCLUSIONS OF LAW AND OPINION

Compensability

We affirm the Referee's opinion with the following comments.

Because claimant's low back condition has been accepted as a compensable condition, it cannot constitute a "preexisting disease or condition." See Richard R. Zippi, 44 Van Natta 1278 (1992); Rosalie S. Drews, 44 Van Natta 36 (1992). Since there is no preexisting condition to combine with claimant's alleged new injury, we find ORS 656.005(7)(a)(B) inapplicable to this case.

The medical evidence does not establish that claimant's work activity was the major cause of a worsening of her underlying low back condition.

ORDER

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

In the Matter of the Compensation of
DAVID T. HANER, Claimant
WCB Case No. 91-03404
ORDER ON REVIEW (REMANDING)
Popick & Merkel, Claimant Attorneys
Beers, et al., Defense Attorneys
D. Kevin Carlson, Assistant Attorney General

Reviewed by Board Members Kinsley and Hooton.

Claimant requests review of Referee Knapp's order that dismissed claimant's hearing request for lack of subject matter jurisdiction. The Department of Insurance and Finance has filed a motion requesting that it be joined as a party to the proceeding and has filed an appellate brief. On review, the issues are joinder and jurisdiction. We deny the motion for joinder and remand.

FINDINGS OF FACT

In February 1985, claimant compensably injured his low back while lifting garbage cans for the employer. He sought treatment from Dr. Brown, who diagnosed a low back strain and provided conservative treatment. After experiencing an onset of leg symptoms, claimant was evaluated by Dr. Markham, a neurosurgeon. Dr. Markham ordered a CT scan and myelogram, which revealed no significant disc abnormalities. Claimant returned to work in November 1985.

In December 1985, claimant began treating with Dr. Suminski, a chiropractor. He diagnosed a chronic thoracic strain with recent thoracic vertebrae fractures, and took claimant off work for approximately five weeks.

In February 1986, a panel of physicians examined claimant at the offices of the Orthopaedic Consultants. They found claimant medically stationary with no physical findings of impairment. They noted, however, that claimant had Scheuermann's disease, a spinal abnormality, and recommended against continued heavy lifting.

Claimant's claim was closed on June 12, 1986, pursuant to a Determination Order that awarded benefits for temporary disability only. A stipulation, approved in March 1987, awarded claimant benefits for 20 percent unscheduled permanent partial disability.

Claimant continued to receive chiropractic treatments from Dr. Suminski. In June 1990, the insurer notified claimant of the legislative amendments to the Workers' Compensation Law regarding attending physicians. Thereafter, claimant returned to Dr. Brown, who authorized six weeks of physical therapy. In August 1990, Dr. Brown reported that claimant's physical therapy was palliative treatment, but necessary to enable him to continue work.

After the insurer denied the request for continued palliative care, Dr. Brown requested approval of the treatment from the Workers' Compensation Division. On January 14, 1991, the Medical Advisor, acting on behalf of the Director, issued an order finding that the requested palliative care was not appropriately related to claimant's compensable injury and was not necessary to enable the worker to continue current employment. The 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. Thereafter, claimant requested a hearing, raising issues of compensability, medical services and "causal relationship of medical treatment/condition."

CONCLUSIONS OF LAW AND OPINION

Motion for Joinder

The Department of Insurance and Finance (Department) has moved to be joined as a party to this proceeding and has filed a position statement. Claimant opposes the motion and argues that the Department lacks standing to intervene as a party.

We have recognized that the Department has standing to intervene as a party where it has a stake in the outcome of the proceeding. For example, in Todd A. Aucone, 37 Van Natta 552 (1985), we held that, because the Department is required to pay certain costs incurred in the processing of claims against a noncomplying employer, the Department had standing to request review of a Referee's order finding an employer to be noncomplying at the time of the claimant's injury. See also John A. Tallant, 42 Van Natta 939 (1990).

In this case, however, the Department does not have a stake in the outcome; it has only a general interest in the interpretation of the applicable statutes and administrative rules. While our decision may affect certain Departmental procedures, we do not find that to be a sufficient interest to allow the Department to intervene in this matter. Accordingly, we conclude that the Department does not have standing to intervene in this proceeding and deny its motion for joinder. We will, however, consider its position statement as amicus curiae.

Jurisdiction

Claimant seeks review of the Referee's order that dismissed his request for hearing for lack of jurisdiction. He argues that the Board has original jurisdiction over his request for hearing regarding palliative care, because he is not otherwise entitled to appeal the Director's order disapproving the treatment. In addition, he contends that the Director exceeded its authority in concluding that the requested palliative care was not causally related to his compensable injury.

This Board answered claimant's first argument in Rexi L. Nicholson, 44 Van Natta 1546 (1992), which held that the Hearings Division lacks original jurisdiction to consider a dispute concerning palliative care, because such disputes are not "matters concerning a claim" under ORS 656.704(3). We also held that the Board lacks jurisdiction to review a Director's order approving or disapproving an attending physician's request for such treatment. Based on the statutory language, and in the absence of any contrary expression of legislative intent, we concluded that jurisdiction over such a dispute rests exclusively with the Director. While the members reviewing this claim dissented in Nicholson, stare decisis requires the application of the principles developed in that case. Accordingly, we agree with that portion of the Referee's order.

We note that, in addition to challenging the Director's order regarding palliative care, claimant raised as an issue in his request for hearing the "causal relationship of medical treatment/condition." Unlike a dispute regarding palliative care, the question whether the need for a requested medical service is casually related to a compensable injury is a "matter concerning a claim," subject to the initial jurisdiction of the Hearings Division. See Michael A. Jaquay, 44 Van Natta 173 (1992). In this case, while the insurer has not officially denied claimant's request for continued medical treatment on casual grounds, we believe that a de facto denial of such services was raised by the insurer's failure to affirmatively respond to claimant's inquiry whether it intended to rely on the Director's determination of noncompensability. Accordingly, we conclude that, notwithstanding the Director's order on palliative care, claimant is entitled to a hearing on the question whether his need for additional medical treatment is casually related to his compensable injury.

We vacate the Referee's order and remand this matter to Referee Knapp for further proceedings consistent with this order. The Referee shall have the discretion to proceed in any manner that will achieve substantial justice and that will ensure a complete and accurate record of all exhibits, examination and/or testimony. Thereafter, the Referee shall issue a final, appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
GLEN L. BURTIS, Claimant
WCB Case No. 91-10430
ORDER ON REVIEW
Charles Lundeen, Defense Attorney

Reviewed by Board Members Brazeau and Gunn.

Claimant, pro se, requests review of Referee Davis' order that affirmed a July 15, 1991 Order on Reconsideration which awarded no scheduled permanent disability. On review, the issue is extent of scheduled permanent disability.

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

The Referee stated that, pursuant to former OAR 436-35-007(9), the findings of the medical arbiter are used to determine impairment under the standards. Former OAR 436-35-007(9) provided that when the impairment findings of the medical arbiter and the attending physician differ, "the findings of the arbiter shall be used to determine impairment under these rules." Subsequent to the Referee's order, we held that former OAR 436-35-007(9) was inconsistent with the applicable statutes and should be given no effect. Instead, impairment is established by the preponderance of medical evidence, considering the medical arbiter's findings and any prior impairment findings. Timothy W. Reintzell, 44 Van Natta 1534 (1992).

After reviewing the record, we find no medical evidence from the attending physician at the time of closure which establishes scheduled permanent impairment. Accordingly, we agree with the Referee that no scheduled permanent disability compensation is awardable.

ORDER

The Referee's order dated November 29, 1991 is affirmed.

October 16, 1992

Cite as 44 Van Natta 2116 (1992)

In the Matter of the Compensation of
MARIE GILBERT, Claimant
Own Motion No. 92-0383M
OWN MOTION ORDER ON RECONSIDERATION
Westmoreland & Shebley, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requested reconsideration of our August 2, 1992 Own Motion Order in the above-captioned case. Claimant contends she has not removed herself from the work force and asked for additional time to submit evidence. In order to allow sufficient time to consider the motion for reconsideration, we abated our prior order on September 4, 1992.

In order to prevail, claimant must prove that she was 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). Claimant has the burden of proof on this issue.

Claimant has submitted a check dated October 9, 1991 for seven hours wages. No other evidence has been submitted. Claimant's condition worsened requiring surgery in April 1992. Although the submitted evidence may establish that claimant was working in October 1991, it does not establish that she was in the work force in April 1992, the time of her disability.

Accordingly, as supplemented herein, we adhere to and republish our August 4, 1992, order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

October 16, 1992

Cite as 44 Van Natta 2117 (1992)

In the Matter of the Compensation of
DONALD L. GRANT, Claimant
 WCB Case No. 92-06280
 ORDER ON RECONSIDERATION (REMANDING)
 Malagon, et al., Claimant Attorneys
 Julene Quinn (Saif), Defense Attorney

Claimant requests reconsideration of our September 29, 1992 order that remanded this matter to the Referee for a determination as to whether Albany Retirement Center, Inc., a noncomplying employer failed to appear at a scheduled hearing and, if so, whether such a failure was justified. Contending that Albany is a corporation, claimant asserts that Albany could not have appeared because no attorney representing its interests attended the scheduled hearing.

Claimant's contentions may prove to be accurate. See ORS 9.320; OAR 438-06-100. Nevertheless, such a determination must be reached by the Referee on remand.

Accordingly, our September 29, 1992 order is withdrawn. On reconsideration, as supplemented herein, we republish our September 29, 1992 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

October 16, 1992

Cite as 44 Van Natta 2117 (1992)

In the Matter of the Compensation of
WANDA TAYLOR, Claimant
 WCB Case No. 91-05115
 ORDER ON REVIEW
 Westmoreland & Shebley, Claimant Attorneys
 Julene M. Quinn (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Barber's order that upheld the SAIF Corporation's denial of claimant's myocardial infarction claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the claim should be analyzed as one for accidental injury, thus applying the material contributing cause standard. We conclude that the claim is more appropriately analyzed as an occupational disease. Recently, the Court of Appeals held 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." SAIF v. Hukari, 113 Or App 475, 480 (1992) (Emphasis in original). Although the court analyzed the 1987 amendments

to ORS 656.802, we have concluded that Hukari is equally applicable to the current version of ORS 656.802. Jerry B. Mathel, 44 Van Natta 1113, on recon 44 Van Natta 1532 (1992).

Here, claimant asserts that her myocardial infarction was caused by job stress. Thus, her claim falls under ORS 656.802; specifically, she must prove compensability pursuant to ORS 656.802(1)(b) and 656.802(3). SAIF v. Hukari, supra. 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).

The record contains three opinions regarding causation. Dr. Toren, cardiologist, who conducted an independent medical examination, concluded that claimant's "myocardial infarction was unlikely to have been related to her work activities." (Ex. 19-1).

Dr. DeMots, head of the cardiology division at OHSU, found that the "notion that stress was responsible for transforming an otherwise healthy person into a person with a myocardial infarction seems highly unlikely. I believe that [claimant] has a predisposition to thrombus formation either due to intrinsic disease of the blood vessels or a condition that predisposes her to clot formation." (Ex. 23-2).

Finally, claimant's treating physician, Dr. Kliks, cardiologist, concluded that claimant sustained a coronary spasm and that such a condition "can certainly be induced by emotional and physical stress. Whether or not the confrontation with her superior at work was directly related to her subsequent event is difficult to say with certainty but not beyond the realm of possibility." (Ex. 18-2). A later report also stated that, "with regard to the relationship of stress at work, I think it is fair to say that one might consider this a possible contributing factor, however, I could not say that had a 'high probability' of being the major contributing factor." (Ex. 21).

Claimant must prove more than the possibility of a causal connection between an injury and employment conditions. See Gormley v. SAIF, 52 Or App 1055, 1060 (1981). We conclude that, because Dr. Kliks stated that a work connection was "not beyond the realm of possibility" and "a possible contributing factor", his opinion does no more than indicate a possible causal connection. Furthermore, we conclude that his opinion only indicates that work is one possible contributing factor and, therefore, does not indicate that it is the major contributing cause of claimant's myocardial infarction. Thus, for both these reasons, we conclude that Dr. Kliks' opinion is insufficient to carry claimant's burden. Because the remaining opinions indicate that work did not cause her myocardial infarction, we conclude that claimant failed to prove compensability.

ORDER

The Referee's order dated February 5, 1992 is affirmed.

In the Matter of the Compensation of
JAMES A. KINSLOW, Claimant
WCB Case No. 91-11500
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Thomas Ewing (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Gunn.

Claimant requests review of Referee Nichols' order that dismissed claimant's hearing request for lack of jurisdiction. On review, the issue is jurisdiction. We conclude that claimant's hearing request is premature and we vacate the Referee's order.

FINDINGS OF FACT

Claimant sustained a compensable low back injury with SAIF's insured in 1988. Following a period of conservative treatment, the claim was closed by a November 1988 Determination Order, which awarded claimant benefits for 13 percent unscheduled permanent partial disability.

Claimant continued to experience low back pain and sought additional medical services from Dr. Carr, a member physician of CareMark Comp, a certified managed care organization (MCO). Carr initially suggested the possibility of surgery, but recommended continued conservative treatment after a psychological evaluation determined that claimant was not a good surgical candidate.

Claimant then came under the care of Dr. Misko, another member physician at CareMark. Misko believed surgical intervention was appropriate and, on August 23, 1991, asked the Medical Review Staff at CareMark for "precertification" to perform surgery. On November 18, 1991, the Medical Review Staff notified Misko that it was denying his request, because the proposed surgery did not meet the established medical screening criteria. It also notified Misko of his right to appeal the decision with the Communication Liaison of CareMark. There is no evidence in the record whether Misko appealed the determination.

Meanwhile, on August 22, 1991, one day prior to Misko's request for precertification, claimant requested a hearing alleging a de facto denial of surgery.

CONCLUSIONS OF LAW AND OPINION

At hearing, SAIF argued that claimant's hearing request was premature and, therefore, ineffective and void. The Referee noted SAIF's argument in the "ISSUES" portion of her order, but did not otherwise address it. On de novo review, we agree with SAIF's contention and vacate the Referee's order.

In Syphers v. K-M Logging, Inc., 51 Or App 769, rev den 291 Or 151 (1981), the claimant requested a hearing on or about the same date his claim was filed. This Board dismissed the claim due to the premature filing of the request for hearing. The court affirmed, holding that until a claim is accepted or denied, or until the period of time has run during which an insurer may investigate the claim, there is no question concerning a claim on which to base a request for hearing and that a request for hearing made during that period of time is premature and void. See also Barr v. EBI Companies, 88 Or App 132 (1987).

In this case, claimant filed a request for hearing alleging a de facto denial of surgery on August 22, 1991. There is no evidence in the record, however, that a claim for the proposed surgery had been made at that time. In fact, it wasn't until the following day, August 23, 1991, that Dr. Misko asked the Medical Review Staff at CareMark for "precertification" to perform surgery. Even if we assume that SAIF was notified of a claim at the time, claimant's hearing request on the compensability of the surgery was premature and therefore ineffective. Syphers v. K-M Logging, Inc., supra. Moreover, the hearing was convened less than 90 days after Dr. Misko's "precertification" request. Under such circumstances, we conclude that any consideration of the surgery at the November 19, 1991 hearing would be premature.

In reaching this decision, we agree with claimant's contention that MCO peer review activities, such as those performed by the Medical Review Staff at CareMark Comp, are meant to be an internal review process only and are intended to be a way for the MCO or insurer to insure that member physicians are following accepted standards of care. See ORS 656.260(4)(d) and (6). We also agree that the peer review activities are not intended to alter the insurer's statutory duty to process the claim under ORS 656.262(1). As with any other medical services claim, SAIF has 90 days after notice to either accept the claim, deny it if it believes the treatment is not causally related to the compensable injury, or initiate Director review if it believes the proposed surgery is not reasonable or necessary. ORS 656.262(6); OAR 436-10-046(3). Nonetheless, as the court explained in Syphers v. K-M Logging, Inc., *supra*:

"The statutory scheme does not reasonably permit a hearing on compensability of the claim prior to a timely acceptance or denial or prior to the time in which the carrier may investigate and consider the claim without risking penalties." 51 Or App at 769.

Without allowing an insurer to process the claim, it is not known whether compensability will be disputed or, if so, whether original jurisdiction over the dispute lies with the Director or the Board. See Michael A. Jaquay, 44 Van Natta 173 (1992); Stanley Meyers, 43 Van Natta 2643 (1991).

ORDER

The Referee's order dated February 4, 1992 is vacated. Claimant's request for hearing is dismissed as premature.

October 19, 1992

Cite as 44 Van Natta 2120 (1992)

In the Matter of the Compensation of
ROBERT L. LEMING, Claimant

WCB Case No. 91-16660

ORDER ON REVIEW

Doblie & Associates, Claimant Attorneys
Thomas Ewing (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of Referee Galton's order that: (1) set aside its denial of claimant's right shoulder injury claim; and (2) assessed a penalty for SAIF'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

Compensability

The Referee found claimant to be a credible and reliable witness. He based his conclusion on claimant's attitude, appearance and demeanor at hearing and while testifying. We defer to that finding, because of the Referee's opportunity to observe the witness. Humphrey v. SAIF, 58 Or App 360 (1982). Relying on that credible testimony, the Referee concluded that claimant had established a compensable right shoulder injury. We agree.

A "compensable injury" is an accidental injury "arising out of and in the course of employment requiring medical services or resulting in disability[.]" ORS 656.005(7)(a). To establish a compensable injury, claimant must show that: (1) he injured himself in performing his job; and (2) the injury sustained was a material contributing cause of the resultant disability or need for medical services. The first element is a question of legal causation; the second concerns medical causation. Harris v. Farmers'

Co-op Creamery, 53 Or App 618 (1981). Claimant carries the burden of proving both legal and medical causation by a preponderance of the evidence. Carter v. Crown Zellerbach Corp., 52 Or App 215 (1981).

In this case, medical causation is not disputed. The issue is whether claimant's right shoulder condition is the result of a work-related injury. SAIF argues that, despite the Referee's express finding, claimant is not a credible witness, because his statements and testimony are inconsistent and that his version of the alleged injury is not believable. It suggests that claimant fabricated the claim, which it believes is "an invention." (App. brief at 8.)

After an objective evaluation of claimant's statement and testimony, we find nothing that casts doubt on his credibility. At hearing, claimant explained in detail the nature of his work and how he injured his right shoulder when a hydraulic jack slipped while he and his supervisor, Mr. Brust, were reinstalling an automobile transaxel. While his testimony indicates that claimant may be attempting to maximize the injurious nature of the event, we do not find that fact sufficient to conclude that claimant is not credible. See Peterson v. Eugene F. Burrill Lumber, 57 Or App 476 (1982). Moreover, while the testimony of claimant's supervisor differed in many respects with that of claimant's, it also supported a finding that claimant sustained a compensable injury. Specifically, Mr. Brust testified that the installation process was awkward and that he himself was straining while he and claimant lifted and wrestled the 150 pound transaxel in place. Furthermore, Mr. Brust also testified that, three days later, claimant told him that he thought that he had strained his shoulder while reinstalling the transaxel.

Finally, we note that claimant's testimony is supported by the medical record. Dr. Manuele, claimant's treating physician, opined that claimant's condition is entirely consistent with an injury involving a sudden increase in load bearing to the right arm. Moreover, while medical causation is not contested, Dr. Manuele's opinion also supports a finding that the industrial injury was a material contributing cause to claimant's disability and need for treatment.

Penalties

The Referee found that SAIF's denial was unreasonable and awarded claimant a penalty under ORS 656.262(10). We affirm.

ORS 656.262(1) provides, in part:

"If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due.

The standard for determining an unreasonable denial is whether the insurer had a legitimate doubt as to its liability. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

In this case, SAIF contends that it had a legitimate doubt as to its liability, because reasonable doubt existed as to the credibility of claimant and that compensability turned on the resolution of the credibility issue. The focus of our inquiry, however, is on the evidence in this record available to SAIF at the time of the denial. Tri-Met, Inc. v. Odighizuwa, 112 Or App 159 (1992). After our review of the record, we find no evidence that predates the denial and which casts doubt on claimant's account of the injury reflected in the claim form, in what he told Mr. Brust three days after the incident, and in the medical reports. The record establishes only that SAIF contacted Mr. Cottis, the owner of the garage, on October 25, 1991, who testified that, at that time, he "was not really aware of an injury per se." (Tr. 61). That, in our opinion, is insufficient to provide SAIF a legitimate basis to doubt its liability.

Attorney Fee on 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 compensability issue is \$1,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's

respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for defending against the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated February 24, 1992 is affirmed. For services on Board review concerning the compensability issue, claimant's counsel is awarded an assessed fee of \$1,000, to be paid by the SAIF Corporation.

October 19, 1992

Cite as 44 Van Natta 2122 (1992)

In the Matter of the Compensation of
ALLEN B. MILLER, Claimant
WCB Case No. 91-08613
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Gunn.

The SAIF Corporation requests review of that portion of Referee Menashe's order that awarded a "penalty-related" attorney fee, based on its failure to timely accept or deny claimant's claim for a work hardening program. Claimant cross-requests review of those portions of the order that: (1) found that his injury claim was not prematurely closed; (2) declined to award an attorney fee under ORS 656.386(1) for his counsel's services in obtaining compensation for claimant without a hearing through the payment for an MRI and a work hardening program. On review, the issues are premature closure and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

SAIF received notice of claimant's claim for a work hardening program on August 19, 1990. (See Ex. 6).

CONCLUSIONS OF LAW AND OPINION

Premature closure

We adopt the Referee's "Opinion and Conclusions" concerning this issue.

Attorney fees

Failure to timely accept or deny

The Referee awarded an attorney fee under ORS 656.382(1), for claimant's counsel's services concerning SAIF's failure to timely process claims for an MRI and a work hardening program. On review, SAIF challenges only the fee associated with the claim for work hardening. In this regard, it acknowledges that Dr. Dodson, claimant's former treating physician, filed a claim for a work hardening program on claimant's behalf. SAIF further admits that it neither accepted nor denied either claim. However, SAIF argues that its failure to respond does not amount to "unreasonable resistance to the payment of compensation," within the meaning of ORS 656.382(1), because Dr. Long, claimant's later treating physician, "withdrew" the claim on March 19, 1991. (See Ex. 17-3).

In Michael A. Dipolito, 44 Van Natta 981 (1992), we held that SAIF had no duty to process a claim for medical services where the request for services had been withdrawn. However, in that case, the claim was withdrawn before the statutory period for investigating the claim had run. Here, in contrast, the claim remained outstanding beyond the 90 days allowed for claim investigation. Although

Dr. Long stated in March 1991 that he did not recommend work hardening, SAIF's duty to timely respond to the August 1990 claim was not thereby absolved. Rather, because SAIF's failure to act is unexplained, it is unreasonable. See Lester v. Weyerhaeuser, 70 Or App 307, 312 (1984). By failing to timely respond to the claim, SAIF delayed the ultimate resolution of the dispute and placed a greater burden on claimant to learn of his rights and to prove his claim. Moreover, SAIF's unexplained inaction had the effect of delaying delivery of benefits under the compensable claim which SAIF ultimately, but belatedly, provided.

SAIF also argues that work hardening is not "compensation" in this case, because it is neither injury-related nor reasonable and necessary. However, SAIF did not avail itself of the opportunity at hearing to contest compensability of the medical services, which it ultimately provided. We, therefore, decline to address SAIF's argument regarding compensability, which it makes for the first time on Board review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991).

Moreover, under ORS 656.382(1), "[c]**ompensation'includes all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to this chapter." ORS 656.005(8). Thus, we conclude that the work hardening program provided by SAIF as treatment for claimant's compensable condition was "compensation," within the meaning of ORS 656.382(1).

Under these circumstances, we conclude that SAIF's refusal to timely accept or deny claimant's claim for a work hardening program amounted to unreasonable resistance to the payment of compensation. Accordingly, since there are no amounts then due upon which to base a penalty, an attorney fee under ORS 656.382(1) is assessed on this basis. See Cameron D. Scott, 44 Van Natta 1723 (1992); 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 agree with the Referee that a reasonable carrier-paid fee for claimant's counsel's services concerning SAIF's failure to respond to the medical services claims (i.e., for work hardening and for an MRI) is \$1,000. In reaching this conclusion, we have particularly considered the time devoted to the issues, as reflected by the record, and the value to claimant of the interest involved.

Obtaining compensation for claimant

Claimant requests an attorney fee, under ORS 656.386(1), for his counsel's services in obtaining compensation under the medical services claims without a hearing. We agree that an assessed fee is appropriate under the statute, because we find that counsel's efforts were instrumental in obtaining compensation for claimant. In reaching this conclusion, we first note SAIF's admission that a work hardening evaluation was provided "at the insistence of claimant's attorney." (Appellant's Brief, p. 2). In addition, we note that the requested medical services were provided after claimant's counsel requested a hearing concerning SAIF's failure to timely accept or deny those services. On these facts, we find that claimant is entitled to an assessed attorney fee under ORS 656.386(1), for his counsel's services prior to hearing in obtaining the payment of the aforementioned compensation without a hearing. See Deborah K. Atchley, 44 Van Natta 1435 (1992).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a \$600 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 January 21, 1992 is reversed in part and affirmed in part. For his services in obtaining compensation for claimant without a hearing, claimant's counsel is awarded an assessed attorney fee of \$600, payable by the SAIF Corporation. The remainder of the order is affirmed.

In the Matter of the Compensation of
DAVID E. MILLS, Claimant
WCB Case Nos. 91-13415 & 91-12237
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Meyers & Radler, Defense Attorneys
Julene M. Quinn (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Moller.

Claimant requests review of Referee Menashe's order that: (1) found that only one employer and its insurer (Crawford & Company, on behalf of McGuire) was responsible for his left hand injury claim; and (2) declined to calculate his rate of temporary disability benefits based on the combined wages earned from both employers. On review, the issues are responsibility and rate of temporary disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Responsibility

On review, claimant contends that the Referee erred by finding that the doctrine of dual (or concurrent) employment did not apply to the facts of this case.

In order to establish a case of dual employment, three elements must be established: (1) a worker must be under contract with two employers; (2) the worker must be under the separate control of each employer; and (3) the worker must perform distinct and separate services for each employer. Mission Insurance Company v. Miller, 73 Or App 159 (1985); Dallas H. Greenslitt, 40 Van Natta 1038 (1988).

In the present case, we agree with claimant that he worked for two employers, he was under the separate control of each, and the work he performed for each employer was distinct. However, such a conclusion does not dictate that both employers are responsible for claimant's injury.

The dispositive question is whether the unloading work that claimant was performing at the time of his injury with McGuire was severable from his job as a furniture mover for WDI. Mission, supra. If so, McGuire is solely responsible for claimant's injury.

We find that claimant's activity at the time of injury was severable because he did not simultaneously perform his duties for McGuire and WDI. Moreover, the evidence establishes that claimant injured his left hand while in the course and scope of his employment with McGuire. There is no evidence that the work activity with MDI contributed to claimant's disability. See Jerry J. Johnson, 43 Van Natta 2758 (1991).

Accordingly, we conclude that the Referee correctly found that only McGuire was responsible for claimant's left hand injury.

Finally, we also agree with the Referee's conclusion that McGuire could be considered a special employer under the loaned-servant doctrine. In Thomas v. A-1 Sandblasting and Steam Cleaning Co., 112 Or App 185 (1992), the court applied the loaned-servant doctrine and found that when a general employer lends an employee to a special employer, the special employer becomes liable for workers' compensation only if:

"(a) the employee has made a contract of hire, express or implied, with the special employer;

"(b) the work being done is essentially that of the special employer; and

"(c) the special employer has the right to control the details of the work."

Thomas, supra; Newport Seafood v. Shine, 71 Or App 119 (1984).

Here, we agree with the Referee that claimant had a contract of hire with McGuire to unload trucks. McGuire paid claimant and kept track of the wages paid to claimant and others for similar work. Moreover, the work being done was performed for McGuire, the special employer, and had nothing to do with claimant's work for WDI. Further, we conclude that McGuire had the right to control the details of the work, as evidenced by the fact that McGuire directed claimant and could terminate his services at any time. Finally, there is no showing that WDI, as claimant's general employer, maintained control over the details of claimant's work while he was "loaned" to McGuire.

Under the circumstances, we find that the elements of the loaned-servant doctrine are present in this case, and we conclude that the Referee correctly concluded that McGuire, as a special employer, is responsible for claimant's left hand injury.

Rate of temporary disability

We adopt the Referee's "Opinion and Conclusion" on the issue of rate of temporary disability.

ORDER

The Referee's order dated December 20, 1991 is affirmed.

October 19, 1992

Cite as 44 Van Natta 2125 (1992)

In the Matter of the Compensation of
GEORGE SCHUKOW, Claimant
WCB Case No. 91-11616
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Gunn and Brazeau.

The SAIF Corporation requests review of that portion of Referee Howell's order that set aside its denial of claimant's psychological condition. Claimant cross-requests review of that portion of the Referee's order that: (1) declined to award additional unscheduled permanent disability; and (2) declined to assess a penalty and related attorney fee for SAIF's alleged failure to accept or deny an aggravation claim within 90 days. On review, the issues are compensability, extent of unscheduled disability and penalties and attorney fees.

We affirm and adopt the Referee's order with the following supplementation concerning the extent of unscheduled permanent disability issue.

The Referee concluded that the findings of impairment made after claimant's condition worsened following the January 1991 Determination Order should be treated as an aggravation claim rather than be considered in rating claimant's permanent disability due to the compensable injury. We agree.

On review, claimant contends that since ORS 656.283(7) requires disability to be evaluated as of the date of the reconsideration order, the worsening of his condition after the January 30, 1991 Determination Order and before the August 30, 1991 Order on Reconsideration should be considered in rating his permanent impairment.

We have previously held that the logical point from which to measure a claimant's worsening is his last opportunity to present evidence on his condition. See Frank L. Stevens, 44 Van Natta 60 (1992); Larry H. Erbs, 42 Van Natta 98 (1990). Thus, we have held that a Determination Order, not an Order

on Reconsideration, is the last opportunity to present evidence on the condition, and, therefore, is also the last arrangement of compensation for purposes of an aggravation claim. Grace M. Nyburg, 44 Van Natta 1875 (1992). It follows that a worsening after claimant's last arrangement of compensation constitutes an aggravation claim rather than impairment which may be rated in determining permanent disability due to the injury. Accordingly, the Referee did not err in treating claimant's post-Determination Order worsening as an aggravation claim rather than considering post-closure medical evidence regarding claimant's worsened condition in rating claimant's permanent disability.

As an alternative issue, claimant raises premature claim closure. However, inasmuch as this issue was not raised before the Referee, we decline to address it on Board review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991).

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is \$1,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated January 27, 1992 is affirmed. For services on review concerning the compensability issue, claimant's attorney is awarded \$1,000 payable by SAIF.

October 19, 1992

Cite as 44 Van Natta 2126 (1992)

In the Matter of the Compensation of
STEVEN F. SUTPHIN, Claimant
 WCB Case No. 91-08908
 ORDER ON REVIEW
 Malagon, et al., Claimant Attorneys
 James Booth (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of those portions of Referee Spangler's order that: (1) directed it to repay claimant an allegedly improper unilateral offset of overpaid temporary disability benefits; (2) declined to authorize the offset; and (3) directed SAIF to pay claimant's scheduled permanent disability award at the rate of \$305 per degree. Claimant moves to strike portions of SAIF's reply brief on the basis that it raised new arguments not raised in the opening brief. On review, the issues are offset, rate of scheduled permanent disability, and appellate procedure. We deny the motion to strike. On the merits, we affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant moved to strike portions of SAIF's reply brief, alleging that those portions raised arguments not previously raised and which were not responsive to claimant's respondent's brief. Alternatively, claimant requested leave to submit a "Supplemental Respondent's Brief," addressing the new arguments raised in SAIF's reply brief.

If a reply brief raises issues not previously raised, those issues will not be considered. Charles L. Pratt, 42 Van Natta 2029 (1990); Richard C. Centeno, 41 Van Natta 619, 620 (1989). In this case, however, SAIF's reply brief merely made a different argument on the same issue raised in the opening

brief. The opening brief addressed the issues of offset and rate of scheduled permanent disability, while the reply brief addressed only the offset issue, arguing that the Director has regulatory authority to prescribe procedures for processing offsets as part of the Notice of Closure. The reply brief argument simply responded to claimant's brief, in which claimant urged the Board to define the procedure for taking "unilateral" offsets. Both arguments focus on the offset issue, which SAIF raised in its opening brief. Since the reply brief did not raise new issues, we deny claimant's motion to strike and do not consider claimant's "supplemental" brief on review.

Offset

The Referee found that SAIF had taken an improper, unilateral offset by failing to "authorize" the offset in its Notice of Closure. Consequently, the Referee ordered SAIF to repay claimant the offset, assessed a penalty equal to 25 percent of the offset, and denied SAIF's request for authorization of the offset. We agree that SAIF improperly processed the offset and that a penalty is warranted. We disagree, however, with those portions of the Referee's order that directed SAIF to repay claimant the amount of the offset and declined to authorize the offset.

The facts of this case are not disputed. On January 11, 1991, SAIF issued a Notice of Closure, closing claimant's claim and awarding scheduled permanent disability benefits valued at \$1,957.50. On January 24, SAIF informed claimant that he had been overpaid \$2,531.25 in temporary disability benefits and that it would deduct the overpayment amount from his award of permanent disability, resulting in no net payment to claimant and a remaining overpayment of \$573.75. Meanwhile, claimant sought reconsideration of the Notice of Closure, and obtained an increased award of permanent disability benefits pursuant to a June 25, 1991 Order on Reconsideration. Shortly thereafter, SAIF again wrote claimant and advised him that it would recoup the remaining overpayment of \$573.75 from the additional benefits awarded.

Claimant acknowledges that an insurer is authorized to unilaterally offset prior overpayments when it closes a claim pursuant to a Notice of Closure. Claimant argues, however, that SAIF's offset here was procedurally improper, because the offset was not included in the Notice of Closure. We agree. ORS 656.268(13) provides:

"Any determination or notice of closure made under this section may include necessary adjustments in compensation paid or payable prior to the determination or notice of closure, including disallowance of permanent disability payments prematurely paid, crediting temporary disability payments against permanent disability awards and payment of temporary disability payments which were payable but not paid."

From a plain reading of the statute, it is clear that an offset is provided by ORS 656.268(13) only if it is included in a Notice of Closure. This allows for a fair and orderly process of compensation, in which not only amounts of awards but also any necessary adjustments to be made from those awards are subject to requirements of proper notice and review.

In this case, SAIF did not advise claimant of the alleged overpayment in the Notice of Closure, nor did SAIF ever issue a corrected Notice of Closure containing the offset information. Moreover, when it did notify claimant by letter a couple weeks later, the letter did not contain any of the statutory prescribed provisions regarding claimant's right to appeal. See ORS 656.270. By failing to properly notify claimant of both the alleged offset and his right to appeal, SAIF lacked authority to unilaterally offset the prior overpayments. Moreover, SAIF's actions constituted an unreasonable delay or refusal to pay compensation, for which claimant is entitled to a penalty equal to 25 percent of the improperly offset amount of \$2,531.25, to be shared equally by claimant and his attorney. ORS 656.262(10). Consequently, we affirm the Referee's penalty assessment.

Nonetheless, at hearing, SAIF requested authorization of the offset. Claimant has not objected to the amount of the overpayment and offset. The Board may authorize recovery of overpayments, and our authority to do so is not confined to the Notice of Closure process addressed in ORS 656.268(13). See SAIF v. Zorich, 94 Or App 661 (1989); Steve E. Maywood, 44 Van Natta 1199 (1992).

We find no reason not to authorize recovery of the overpayment in this case. Claimant is substantively entitled to temporary disability only from the onset of disability until the condition is medically stationary. See Lebanon Plywood v. Seiber, 113 Or App 651 (1992). Accordingly, we approve SAIF's request for an offset of temporary disability benefits paid after the medically stationary date.

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). Accordingly, we reverse those portions of the Referee's order which directed SAIF to pay claimant's 12 percent scheduled permanent disability award at the rate of \$305 per degree, and awarded claimant's attorney a fee equal to 25 percent of the additional scheduled permanent disability compensation created by his order.

ORDER

The Referee's order dated November 12, 1991, as corrected November 13, 1991, is reversed in part and affirmed in part. We reverse those portions of the Referee's order that: (1) ordered the SAIF Corporation to repay claimant the offset of \$2,531.25; (2) awarded an approved attorney fee equal to 25 percent of the repaid amount; (3) denied the SAIF Corporation's request for authorization of the \$2,531.25 offset; (4) ordered claimant's scheduled permanent disability award to be paid at the rate of \$305 per degree; and (5) directed SAIF to pay claimant's attorney a fee equal to 25 percent of the increased scheduled permanent disability compensation created by his order. Instead, we approve SAIF's request for authorization of an offset of \$2,531.25. The remainder of the Referee's order is affirmed.

October 19, 1992

Cite as 44 Van Natta 2128 (1992)

In the Matter of the Compensation of
ROBIN G. WHITFIELD, Claimant
 WCB Case No. 91-13394
 ORDER ON REVIEW
 Welch, et al., Claimant Attorneys
 Jerome Larkin (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Gunn.

The SAIF Corporation requests review of Referee Podnar's order that awarded claimant 17 percent (54.4 degrees) unscheduled permanent disability, whereas an Order on Reconsideration had awarded no permanent disability. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exceptions. We do not adopt the last two sentences in the fourth paragraph and we do not adopt the last sentence of the Referee's findings.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the temporary standards which were in effect on the date of the Notice of Closure were invalid. The Referee, therefore, applied the previous permanent standards to rate the extent of claimant's disability. Subsequent to the Referee's order, we recently held that neither a referee nor the Board has authority to declare the aforementioned temporary rules invalid. Eileen N. Ferguson, 44 Van Natta 1811 (1992). Accordingly, in conducting our "de novo" review, we apply the standards in effect on the date of closure.

Former OAR 436-35-270 through 436-35-440, as amended by temporary rules in effect at the time of the March 7, 1991 Notice 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.

Age

The appropriate value for claimant's age of 34 years is 0. Former OAR 436-35-290 (Temp).

Formal Education

Claimant has earned a high school diploma. Therefore, the value for formal education is 0. Former OAR 436-35-300(3)(a) (Temp).

Skills

Of those SVPs the worker met during the 10 years before the time of determination, the highest SVP number is used to determine the appropriate skills value from the table at former OAR 436-35-300(4)(e) (Temp).

Based upon claimant's job performance, the job title describing the job for which claimant met the highest SVP number during the 10 years prior to the time of determination was psychiatric aide, DOT # 355.377-014. That job title is assigned an SVP number of 4 by the SCODDOT. Therefore, claimant is entitled to a skills value of 3. Former OAR 436-35-300(4)(e) (Temp).

Claimant's total education value is 3, the sum of the values for formal education and skills. Former OAR 436-35-300(5) (Temp).

Adaptability

For workers who have been offered "modified work" or who are working at "modified work" at the "time of determination," an adaptability value is obtained from the matrix of values at former OAR 436-35-310(3)(d) (Temp). Former OAR 436-35-310(3)(a)&(b) (Temp).

In order to determine the appropriate value from the matrix, the physical capacity category for a worker's regular work is obtained from the Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles (SCODDOT) for the Dictionary of Occupational Titles (DOT) job title which most nearly reflects the duties of the regular work. Former OAR 436-35-310(3)(d) (Temp.). The physical capacity category for the modified work is determined from the physical capacities necessary to perform the modified work and the descriptions of physical capacities contained in former OAR 436-35-270(3)(e)-(j) (Temp.). Former OAR 436-35-007(10) (Temp.)

Here, the DOT job title most accurately reflecting claimant's regular work is psychiatric aide (DOT# 355.377-014). The SCODDOT identifies that job as being in the medium category. The physical capacity required to perform claimant's modified work was sedentary. Therefore, the appropriate adaptability value is 2.5.

Impairment

Dr. Corrigan found that left rotation of the cervical spine was 60 degrees and left lateral flexion was 40 degrees. Based on those findings, claimant is entitled to a value of 1.33 percent for lost range of motion in the cervical spine. Former OAR 436-35-360(5); Former OAR 436-35-360(4).

The Referee also awarded claimant 2 percent impairment for a loss of left shoulder abduction. However, inasmuch as Dr. Corrigan concluded that claimant had no measurable losses in the left shoulder, we find that no award for the left shoulder is appropriate.

The Referee also found a chronic condition limiting repetitive use of the shoulder. Impairment must be measured by a physician. Former OAR 436-35-005(2). Here, Dr. Corrigan's report does not support a chronic condition award for the cervical/upper back/shoulder area. See former OAR 436-35-320(5). Accordingly, we find that claimant is not entitled to an award for a chronic condition.

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 (3) is 3. The product of that value and the value for claimant's adaptability (2.5) is 7.5. The sum of that product and the value for claimant's impairment (1.33) is 8.83. That value (after rounding) represents claimant's unscheduled disability. Accordingly, claimant's unscheduled permanent disability is 9 percent.

SAIF argues that pursuant to former OAR 436-35-007(3), claimant's unscheduled award for her 1989 injury to the same body part should be subtracted on a degree per degree basis from the current award.

We have held that, pursuant to ORS 656.214(5), 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. Mary A. Vogelaar, 43 Van Natta 1370 (1991). In Vogelaar, we rated claimant's permanent disability under the standards, and then we determined whether, and to what extent that disability was related to the prior compensable injury as opposed to the current injury.

Here, the parties stipulated that at the time she suffered the 1990 compensable injury, claimant had no residual disability related to the 1989 injury. (Tr. 13). Considering that the parties agree that all of the permanent disability claimant now suffers from is due to the current injury, we find that none of claimant's permanent disability represents impairment due to the 1989 injury which may be offset. See Anita F. Saltmarsh, 43 Van Natta 355 (1991). Accordingly, we conclude that, as there is no disability due to the prior injury, OAR 436-35-007(3) has no application to this case.

ORDER

The Referee's order dated January 10, 1992 is modified. In lieu of the Referee's award, claimant is awarded 9 percent (28.8 degrees) unscheduled permanent partial disability. In lieu of the Referee's attorney fee award, claimant's attorney is awarded 25 percent of this 9 percent award, not to exceed \$2,800.

In the Matter of the Compensation of
JOSEPH L. GAMBLE, Claimant
WCB Case No. 91-05124
ORDER ON REVIEW
Hollander, et al., Claimant Attorneys
Julene Quinn (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of Referee Hoguet's order that awarded claimant's attorney an assessed attorney fee. Following submission of briefs by counsel, claimant moved to submit additional evidence. On review, the issues are motion to remand and attorney fees. We deny the motion and reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Motion to Remand

Claimant seeks to admit a letter from SAIF advising him that it has reopened his claim. We view claimant's submission as a motion for remand. Judy A. Britton, 37 Van Natta 1262 (1985). We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Olson, 37 Van Natta 1054, 1055 (1986), aff'd mem, 80 Or App 152 (1986). We consider the proffered evidence only to determine whether remand is appropriate.

Here, the record does not establish that the material claimant now seeks to admit was unobtainable at the time of hearing with due diligence. The letter in question was mailed to claimant on January 7, 1992, whereas written closing arguments were filed with the Referee from late January through mid-February 1992. The record was closed on February 18, 1992 and the Referee did not issue an order until March 10, 1992. In any event, we do not consider the present record (without the inclusion of this letter) to be improperly, incompletely, or insufficiently developed concerning the issue in dispute in this case. For these reasons, claimant's motion for remand is denied.

Attorney Fees

The sole issue is whether claimant's counsel is entitled to an assessed attorney fee for services rendered in obtaining a rescission of a disclaimer of responsibility. Finding that the disclaimer was the equivalent of a denial of a claim for compensation, the Referee determined that he was so entitled. Based on David Jones 44 Van Natta 1752, (1992), a decision issued subsequent to the Referee's order, we disagree and reverse.

The requirements of a notice of intent to disclaim responsibility are set forth in ORS 656.308(2) and OAR 438-05-053. SAIF's April 17, 1991 letter, captioned "DISCLAIMER OF RESPONSIBILITY," fully conformed with OAR 438-05-053(1) and (3). From the plain language of that rule, 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. The notice is not intended to act as a denial of compensation, the procedures of which are contained in ORS 656.262(6). David Jones, supra. Moreover, subsections (2) and (4) of OAR 438-05-053 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.

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). David Jones, supra. Further, even if we were to find that the notice was an actual denial of responsibility, an assessed 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 March 10, 1992 is reversed.

October 20, 1992

Cite as 44 Van Natta 2132 (1992)

In the Matter of the Compensation of
JOSEPH P. GROTHE, Claimant
 WCB Case Nos. 91-08176 & 91-14897
 ORDER ON REVIEW
 Pozzi, et al., Claimant Attorneys
 Nancy J. Meserow, Defense Attorney
 Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Brazeau.

Claimant requests review of Referee Knapp's order that: (1) upheld American International Adjustment Company's (AIAC) denial of responsibility for claimant's aggravation claim for a left elbow condition; (2) upheld GAB Business Systems' (GAB) partial denial of responsibility for claimant's "new" occupational disease claim for the same condition; (3) did not award claimant's counsel an assessed attorney fee for his efforts in obtaining GAB's rescission of its responsibility denial of claimant's right elbow condition; and (4) did not assess penalties and related attorney fees for GAB's allegedly unreasonable claims processing. On review, the issues are res judicata, aggravation, compensability, penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

At the commencement of the hearing, GAB clarified and amended its partial denial. Whereas the written denial stated that GAB was denying "responsibility for disability and medical treatment as it relates to your bilateral epicondylitis," GAB counsel indicated that the denial was intended to refer "only to the left elbow condition."

CONCLUSIONS OF LAW AND OPINION

As a threshold matter, we acknowledge that subsequent to the filing of Board briefs, AIAC submitted a Memorandum of Additional Authority pertaining to the responsibility issue. It is permissible for any party to provide supplemental authorities to assist the Board in its review of a case. See Betty L. Juneau, 38 Van Natta 553, 556 (1986). Here, AIAC cites to a recent Board decision relevant to an issue at hand. Accordingly, we allow AIAC's submission, but consider it only to the extent that it advises us of a recent development in the law. See Debra A. West, 43 Van Natta 2299 (1991). We now turn to the merits of the case.

AIAC's Denial

Claimant raises but does not discuss this issue. Following our de novo review of the record, we adopt the Referee's reasoning and conclusion that res judicata bars claimant's aggravation claim against AIAC.

GAB's Denial

We affirm the Referee's reasoning and conclusion that, during GAB's coverage, claimant did not sustain a "new" occupational disease affecting the left elbow. ORS 656.802(1)(c)(2); see Donald C. Moon, 43 Van Natta 2679 (1991). We do not agree with the assertions of claimant and AIAC that Dr. Weintraub's reports establish that claimant's work activities on and after October 1, 1989 were the major contributing cause of a pathological worsening of his left elbow condition. Although Dr. Weintraub indicated his concurrence with a statement in a letter from claimant's counsel to that effect (Ex. 43), Dr. Weintraub earlier reported that claimant's "elbow condition was already well established and chronic and is most related to his work activities prior to October 1, 1989 rather than afterward." (Ex. 37). Moreover, Dr. Weintraub's subsequent opinion offers no explanation as to why claimant's condition "pathologically" worsened rather than symptomatically worsened. Under the circumstances, his opinion is not persuasive.

We next address the Referee's alternate conclusion that because the "preexisting" left elbow condition is the major contributing cause of claimant's current left elbow disability and need for treatment, claimant cannot establish a new compensable condition under ORS 656.005(7)(a)(B). Subsequent to the Referee's order, we held that a compensable condition does not constitute a "preexisting" condition under ORS 656.005(7)(a)(B). Rosalie S. Drews, 44 Van Natta 36 (1992). Neither is that statute applicable in the responsibility context. Id. Only because claimant's current left elbow condition represents a "new" occupational disease claim is the major contributing cause standard applicable. ORS 656.802(1)(c), and (2).

AIAC, the last insurer against whom claimant had an accepted left elbow claim, remains responsible for claimant's left elbow condition unless it establishes that work activities while GAB provided coverage were the major contributing cause of claimant's left elbow condition. See Rodney H. Gabel, 43 Van Natta 2662, 2664 (1991). AIAC has not established that claimant suffered a "new" occupational disease during his later work activities. Were claimant not barred from bringing this current claim against AIAC, AIAC would be responsible for claimant's current left elbow aggravation claim. See Rodney H. Gabel, *supra*. Nevertheless, AIAC remains responsible for future benefits insofar as they are related to claimant's accepted left elbow condition.

Penalties and Attorney Fees

On review, claimant contends that he is entitled to an assessed attorney fee for his counsel's services in obtaining GAB's rescission of its partial denial of responsibility for claimant's right elbow condition. In addition, claimant seeks penalties and attorney fees for GAB's allegedly unreasonable claim processing of his elbow conditions.

ORS 656.386(1), as amended June 19, 1991, allows an attorney fee if an attorney is instrumental in obtaining compensation, even though a hearing is not held. Here, however, GAB did not deny the compensability of claimant's right elbow condition, but rather denied responsibility for the condition. If an insurer denies responsibility, but not compensability, it has not denied a claim for compensation. Multnomah County School Dist. v. Tigner, 113 Or App 405 (1992); David Jones, 44 Van Natta 1752 (1992). Because GAB's denial of responsibility was not a denial of compensation, claimant's attorney is not entitled to an assessed fee under ORS 656.386(1). See Id.; Jack A. Crates 44 Van Natta 2078 (1992).

Moreover, we find no basis for assessing penalties and attorney fees for GAB's allegedly unreasonable claim processing. In support of his contention, claimant recites that GAB neglected to obtain evidence on his right elbow condition for 14 months. He appears to suggest that GAB did not respond to a May 1990 claim until June 1991. The record does not substantiate this. Claimant sustained a right elbow injury on May 26, 1990, which GAB accepted on August 22, 1990 as a temporary worsening of right epicondylitis. On this record, there is no basis to assess a penalty or attorney fee for failure to process claimant's right elbow claim.

Finally, because we have found claimant's left elbow condition not to be compensable, there are no "amounts then due" upon which to base a penalty and no unreasonable resistance to the payment of compensation to support an award of a penalty-related attorney fee on that claim. See Boehr v. Mid-

Willamette Valley Food, 109 Or App 292 (1991); Randall v. Liberty Northwest Insurance Corp., 107 Or App 599 (1991).

ORDER

The Referee's order dated October 29, 1991 is affirmed.

October 20, 1992

Cite as 44 Van Natta 2134 (1992)

In the Matter of the Compensation of
DALE A. PRITCHETT, Claimant
WCB Case No. 91-13947 & 91-14183
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Moller and Brazeau.

The self-insured employer requests review of those portions of Referee Livesley's order that: (1) declined to set aside an Order on Reconsideration as invalidly issued; (2) found that the Hearings Division has jurisdiction over this matter; (3) affirmed an Order on Reconsideration that awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the right (forearm) wrist, whereas a Notice of Closure had awarded no permanent disability; and (4) assessed a \$1,200 attorney fee for claimant's counsel's services concerning the validity of the reconsideration order and extent of permanent disability award issues. On review, the issues are jurisdiction, validity of the Order on Reconsideration, extent of scheduled permanent disability, and attorney fees. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable right wrist injury on March 5, 1990.

Dr. Woolpert, orthopedic surgeon, performed an independent medical examination on April 4, 1991. A Notice of Closure issued on May 13, 1991 awarding claimant no permanent disability. Dr. Kuller, claimant's attending orthopedic physician, performed a closing examination on May 20, 1991.

Claimant filed a request for reconsideration on August 27, 1991. In bold print, boxes number 4 and 5 on the form provided by the Department of Insurance and Finance (DIF) reference "Impairment findings by the attending physician at time of claim closure," and "Scheduled Permanent Partial Disability," as grounds for reconsideration. Claimant checked those boxes, and enclosed a copy of his attending physician's closing examination. In the narrative cover letter accompanying his request for reconsideration, claimant urged the Appellate Unit to award him a "five percent scheduled permanent disability rating based on the opinion of the attending physician."

An Order on Reconsideration issued on September 13, 1991. Based on Dr. Kuller's impairment findings, claimant was awarded 5 percent permanent scheduled disability for loss of repetitive use of the right wrist.

CONCLUSIONS OF LAW AND OPINION

As a threshold matter, we acknowledge that subsequent to the filing of Board briefs in this case, the parties submitted Memorandums of Additional Authorities pertaining to the validity of the Order on Reconsideration and jurisdictional issues. It is permissible for any party to provide supplemental authorities to assist the Board in its review of a case. However, further argument will not be considered. See Betty L. Juneau, 38 Van Natta 553, 556 (1986). Accordingly, we allow the parties' submissions, but consider them only to the extent that they advise us of recent developments in the law. See Debra A. West, 43 Van Natta 2299 (1991).

Jurisdiction

Although he found that the Appellate Unit had not completed all of the requirements contemplated by ORS 656.268 prior to issuing the Order on Reconsideration, the Referee nonetheless concluded that jurisdiction over the extent of disability issue rests with the Hearings Division. We agree with the Referee's ultimate conclusion; however, we do so for the following reasons.

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, recon den 44 Van Natta 1609 (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.

Whether a party has raised an objection to the findings of impairment by the attending physician, so that appointment of an arbiter is required, is a question of fact.

Here, claimant objected to the fact that the order issued without consideration of the attending physician's findings, rather than to the actual findings themselves. Claimant's request for reconsideration recited Dr. Kuller's findings, and asserted that a "five percent scheduled permanent disability rating should be granted based on the opinion of the attending physician" (emphasis supplied). We are unwilling to find that the mere checking of a box controls when, as here, the narrative request accompanying the printed form clearly relies on the physician's findings in asserting entitlement to an increased scheduled permanent disability award. Under these circumstances, we conclude that the order on reconsideration is valid despite the absence of a medical arbiter and that we have jurisdiction to review the award. See Doris C. Carter, supra. We now turn to the merits of the case.

Extent of Scheduled Permanent Disability

We agree with and adopt that portion of the Referee's order that affirmed the Order on Reconsideration awarding claimant 5 percent scheduled permanent disability for chronic loss of use or function of the right wrist.

Attorney Fees At Hearing

Finally, the employer argues that the Referee's attorney fee award for claimant's counsel's services 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 concerning the validity of the reconsideration order and extent of permanent disability award issues is \$1,200, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as set forth in claimant's brief and demonstrated by the record), and the value of the interest to claimant. Accordingly, we affirm the Referee's \$1,200 attorney fee award.

Claimant's attorney is entitled to a reasonable assessed fee for his services on review defending against the employer's appeal of the validity and extent of the permanent disability award. 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 validity and extent of the permanent disability award issues is \$800, 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. Inasmuch as attorney fees are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an

attorney fee for that portion of his services on review defending 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 March 3, 1992 is affirmed. For services on review concerning the validity and extent of permanent disability award issues, claimant's counsel is awarded a reasonable attorney fee of \$800, payable by the self-insured employer.

October 20, 1992

Cite as 44 Van Natta 2136 (1992)

In the Matter of the Compensation of
WILLIAM L. STONE, Claimant
 WCB Case No. 91-07966
 ORDER ON REVIEW
 Malagon, et al., Claimant Attorneys
 Beers, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Kinsley.

Claimant requests review of Referee Howell's order which upheld the insurer's denial of claimant's aggravation claim for a worsened psychological condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

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

A previous referee's order following a January 25, 1990 hearing concluded that claimant was not permanently and totally disabled and was not entitled to additional unscheduled permanent disability beyond the 29 percent awarded by a 1988 Determination Order. That order was subsequently reviewed and affirmed by the Board. On November 16, 1991, the Court of Appeals affirmed the Board's order.

At the time of the January 25, 1990 hearing, the last arrangement of compensation, claimant had some ability to do gunsmithing and woodworking on a piecemeal basis in his home machine shop. After the January 25, 1990 hearing, claimant's depression and anxiety worsened and, as a result, claimant is no longer capable of working, even on a piecemeal basis.

CONCLUSIONS OF LAW AND OPINION

Aggravation

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). To prove a compensable worsening of his unscheduled condition, claimant must show that increased symptoms or a worsened underlying condition resulted in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Additionally, because claimant has previously been awarded unscheduled permanent disability, he must also establish that the worsening is more than waxing and waning of symptoms contemplated by the previous permanent disability award. ORS 656.273(8).

The Referee correctly concluded that claimant had established that his unscheduled psychological condition had worsened since the last arrangement of compensation and that this worsening was more than a waxing and waning of symptoms contemplated by the previous permanent disability award. We agree with the Referee's reasoning and conclusions regarding claimant's worsened condition and, therefore, we adopt that portion of the Referee's order.

However, the Referee further concluded that claimant failed to prove that his worsened condition resulted in a loss of earning capacity. In reaching that conclusion, the Referee relied solely on

the opinion of Dr. Carter, claimant's treating psychiatrist. Moreover, in relying on Dr. Carter's opinion, the Referee interpreted it to mean that claimant was unable to work both before and after the last arrangement of compensation. We disagree.

At the outset, we note that following the January 25, 1990 hearing, the previous referee determined that claimant was not permanently and totally disabled and was not entitled to additional unscheduled permanent disability for his compensable psychological condition beyond the 29 percent awarded by a 1988 Determination Order. (Ex. 93). That order was subsequently affirmed by the Board and by the Court of Appeals. Consequently, we conclude that as of the time of his last arrangement of compensation, claimant had only a 29 percent loss of earning capacity and was not permanently and totally disabled as a matter of law.

We turn to claimant's current disability and loss of earning capacity. Prior to January 25, 1990, Dr. Carter opined on an insurer's preprinted form that claimant was incapable of returning to any full-time or regular part-time "vocational function." (Exs. 61, 73, 76, 87). However, Dr. Carter also indicated that claimant's depression and anxiety was gradually resolving (Ex. 65-7) and that, with supervision, claimant was capable of working two to four hours with rest breaks. (Ex. 83-2). Moreover, he noted that claimant had acquired skills in custom gunsmithing and woodworking which might afford a means of earning income on a piecework basis in his home machine shop. (Exs. 65-9, 83-2, 103-3). After January 25, 1990, Dr. Carter opined that due to claimant's increased depression and anxiety, claimant was no longer able to perform even piecework. (Ex. 111-3, 116A-1, 121-1, 121-2).

We also find that the employability assessments done by vocational consultant Russ Carter support the conclusion that prior to January 25, 1990, claimant was capable of gainful employment. Following a thorough skills analysis, Mr. Carter opined in his December 22, 1988 report that claimant was employable within the light to sedentary classification and listed a number of jobs that claimant was capable of performing. (Ex. 66-8, 66-9, 66-11). Additionally, in his December 22, 1989 report, Mr. Carter opined that claimant was capable of performing a number of jobs in the sedentary or light strength and unskilled or semi-skilled categories. (Ex. 92-1). We note that a third employability assessment done by Robert Demears prior to January 25, 1990 suggested that claimant was incapable of working (Ex. 91-3, 91-4). We do not find this report persuasive, however, in light of the remaining evidence.

Consequently, we conclude that on this record, claimant established a loss of earning capacity since the last arrangement of compensation. See Smith v. SAIF, *supra*; Edward D. Lucas, *supra*. Claimant's aggravation claim is compensable.

Attorney Fee

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 attorney fee for claimant's counsel's services at hearing and on review concerning the aggravation issue is \$4,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the appellate briefs, the record and claimant's attorney's statement of services), the complexity of the issue, the value of the interest involved and the risk that claimant's attorney's efforts would go uncompensated in this case.

ORDER

The Referee's order dated December 24, 1991 is reversed. The insurer's aggravation denial is set aside and the claim is remanded to the insurer for further processing according to law. Claimant's attorney is awarded an assessed fee of \$4,500, to be paid by the insurer, for services rendered at hearing and on review concerning the aggravation issue.

In the Matter of the Compensation of
CYNTHIA L. McHENRY, Claimant
WCB Case No. 89-11304
ORDER ON REVIEW
Willard Bodtker, Claimant Attorney
Sandra K. Haynes, Defense Attorney
Bonnie V. Laux (Saif), Defense Attorney

Reviewed by Board Members Moller and Brazeau.

The noncomplying employer requests review of that portion of Referee Quillinan's order that upheld the SAIF Corporation's acceptance of claimant's left shoulder condition as a compensable injury. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we note that the Referee upheld SAIF's acceptance of the claim and dismissed the employer's request for hearing. No party requested that she dismiss the request. Moreover, we are aware of no other authority supporting a dismissal, absent such a request. Therefore, we reinstate the employer's hearing request.

On review, the employer contends that the Referee was not an impartial fact-finder. She requests, therefore, that this Board reverse the Referee's finding that claimant's left shoulder condition is compensable. In support of her allegation of partiality, the employer points to the Referee's observation concerning a recognized anomaly in Oregon Workers' Compensation Law. Thus, the employer argues, because the Referee is biased concerning the law, she was biased against the employer.

The record does not substantiate the employer's allegation of partiality. To the contrary, the hearing transcript demonstrates that the Referee showed every consideration to all parties in her conduct of the hearing. The Referee applied the legal position advanced by the employer, and found that noncomplying employers can challenge the compensability of accepted claims at any time. She then concluded, as the employer advocated, that the employer's request for hearing was timely. We find nothing in the record to suggest that the hearing was conducted in any manner other than one which would achieve substantial justice. ORS 656.283(7).

On the merits, we affirm and adopt the Referee's reasonings and conclusion that claimant has established, by objective medical evidence, that she sustained a left shoulder strain in the course of her employment.

For successfully defending against the employer's request for review, claimant's counsel is entitled to a reasonable assessed fee. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is \$750, payable by SAIF on behalf of 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 employer's hearing request is reinstated. The Referee's order dated November 27, 1991 is affirmed. For services on Board review, claimant's counsel is awarded a reasonable assessed attorney fee of \$750, payable by SAIF on behalf of the noncomplying employer.

In the Matter of the Compensation of
ERNEST R. MILLER, Claimant
Own Motion No. 92-0210M
OWN MOTION ORDER REFERRING FOR FACT FINDING HEARING
Emmons, et al., Claimant Attorneys
Nancy J. Meserow, Defense Attorney

The insurer has requested reconsideration of the Board's August 28, 1992 Order on Reconsideration that reopened claimant's claim for temporary total disability compensation. In order to allow sufficient time for claimant to respond, we abated our prior order on September 28, 1992.

On July 29, 1992, we issued an Own Motion order denying reopening on the basis that claimant had not established that he was in the work force at the time of his disability which resulted in surgery. On August 20, 1992, we received claimant's request for reconsideration. With his request, claimant submitted additional evidence in support of his contention that he was in the work force at the time of his disability.

On August 28, 1992, without awaiting a response from the insurer, we issued our Order on Reconsideration reopening claimant's claim. In that order, we relied on the evidence submitted by claimant. Thereafter, the insurer requested reconsideration. With its request, the insurer submitted additional evidence in support of its contention that claimant was not in the work force at the time of his disability.

Under such circumstances, we conclude this is an appropriate matter for referral to the Hearings Division for an evidentiary hearing. OAR 438-12-040. Accordingly, we refer this matter to the Hearings Division for an evidentiary hearing.

The parties shall submit their testimonial and documentary evidence concerning the withdrawal from the "work force" issue. The Referee shall make findings of fact regarding whether claimant was in the work force at the time of his disability which resulted in surgery, and forward a recommendation to the Board. See Arthur R. Morris, 42 Van Natta 2820 (1990). The Referee shall conduct this hearing in any manner that will achieve substantial justice to all parties. Following the hearing and closure of the record, we shall implement a briefing schedule and, upon its completion, proceed with our review.

IT IS SO ORDERED.

October 22, 1992

Cite as 44 Van Natta 2139 (1992)

In the Matter of the Compensation of
ROBERT D. BLANCHFIELD, JR., Claimant
WCB Case No. 91-01777
ORDER ON RECONSIDERATION (REMANDING)
W. D. Bates, Jr., Claimant Attorney
Employers Defense Counsel, Defense Attorneys

Claimant requested reconsideration of our August 7, 1992 Order on Review that upheld the insurer's denial of his claim for a low back injury. On September 3, 1992, we abated our prior order in order to fully consider the matter and granted the insurer an opportunity to respond. After receiving the insurer's response, and further considering the matter, we remand.

Claimant contends that this matter should be remanded to the Referee for further consideration. In support of this contention claimant has attached a letter from James Bridges, a witness at the hearing, purporting to withdraw his testimony at hearing. In the letter, Mr. Bridges indicates that he is withdrawing his testimony because, due to illness, he was confused and did not properly remember facts to which he testified.

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

Here, the Referee found the testimony of Mr. Goff and Mr. Bridges credible and stated:

"In contrast, the persuasiveness of claimant's testimony is diminished by his poor recollection, which may have been [sic] contributed to the deficiencies in the history of Dr. Hacker, who was unaware of claimant's slip on the ice or his hunting and football activities."

Under these circumstances, we conclude that claimant's credibility and reliability relative to that of Mr. Goff and Mr. Bridges were central considerations in the Referee's conclusion. In view of Mr. Bridges' withdrawal of his testimony, we conclude that the record before the Referee was incompletely developed. See Jose L. Cervantes, 41 Van Natta 2419 (1989).

Accordingly, we withdraw our August 7, 1992 Order on Review. On reconsideration, we vacate the Referee's order dated September 6, 1991. This matter is remanded to the Referee for further proceedings to determine whether and to what extent the decision by Mr. Bridges to withdraw his prior testimony affects the ultimate outcome of this dispute. These further proceedings may be conducted in any manner that the Referee determines will achieve substantial justice. Following these further proceedings, the Referee shall issue a final appealable order concerning the issues raised in this case.

IT IS SO ORDERED.

October 22, 1992

Cite as 44 Van Natta 2140 (1992)

In the Matter of the Compensation of
JULIO MEJIA, Claimant
WCB Case No. TP-92010
THIRD PARTY DISTRIBUTION ORDER
Doblie & Associates, Claimant Attorneys
Roberts, et al., Defense Attorneys

Travelers Insurance Company, as a paying agency, has petitioned the Board to resolve a dispute concerning whether it is entitled to a share of a judgment claimant has recovered stemming from injuries he sustained as a result of a non-work-related motor vehicle accident. Following the motor vehicle accident, claimant's bilateral knee claim was reopened by a Referee's order which found that claimant had established an aggravation of his compensable bilateral knee condition.

Travelers asserts a "current lien" in the amount of \$18,819.80, which includes medical services and temporary disability benefits paid as a result of the reopening of claimant's claim. In addition, Travelers asserts a future lien to include further permanent and temporary disability benefits and medical and vocational services to be paid on claimant's knee claim. Noting that claimant's permanent disability resulting from his aggravation claim has not been finally determined, Travelers asks reimbursement of its current lien and requests that claimant's attorney be directed to retain the remaining balance of settlement proceeds in trust pending that final determination. We grant Travelers' request.

FINDINGS OF FACT

In December 1984, claimant sustained a compensable injury to both knees when he fell at work. He had several surgeries on both knees. Claimant attempted to return to modified work in June 1989.

In September 1989, claimant was examined by Dr. Burroughs who found that his knees had not improved. He also found that the degenerative process in claimant's knees was proceeding at a rapid rate, and he recommended that claimant discontinue his work with the employer.

On October 12, 1989, a Determination Order issued, finding claimant medically stationary on September 24, 1989. The Determination Order awarded temporary and permanent disability benefits. Claimant requested a hearing contesting the Determination Order.

In November 1989, claimant was involved in an off-the-job motor vehicle accident with another vehicle. He sustained injuries to several areas of his body, including further trauma to both knees.

On January 4, 1990, Dr. DiPaola, claimant's treating physician following the auto accident, reported that he was experiencing an exacerbation of his previous knee problems. Claimant's request to reopen his claim was denied by Travelers. Claimant filed a hearing request regarding Travelers' denial.

On March 28, 1990, a Referee's order modified the October 1989 Determination Order, found claimant to be medically stationary on June 29, 1989, and awarded temporary disability benefits from April 24, 1989 through June 29, 1989. The Referee also set aside the aggravation denial and found that claimant's condition had worsened during mid-June 1989 and mid-September 1989 and claimant had not become medically stationary since the worsening.

A January 23, 1991 Determination Order closed claimant's aggravation claim. Claimant was awarded temporary disability benefits from September 11, 1989 through August 6, 1990. The Determination Order found claimant to be medically stationary on August 6, 1990.

Claimant appealed the Determination Order and requested a hearing on the issues of premature closure and extent of permanent disability. That hearing request is presently pending before the Hearings Division.

A March 6, 1991 Board order modified the Referee's March 28, 1990 order. Claimant was found medically stationary on September 6, 1989. The Board order affirmed the portion of the Referee's order which set aside the aggravation denial. In so doing, the Board found that claimant's knee condition worsened following the motor vehicle accident, as compared to his condition at the time of the October 12, 1989 Determination Order.

Claimant retained legal counsel to pursue a cause of action against the establishment that furnished alcoholic beverages to the driver of the other vehicle involved in the accident. In July 1992, claimant was awarded a judgment of \$200,000 by a Federal District Court jury.

Following the motor vehicle accident, Travelers paid claimant temporary disability benefits from November 1989 through January 6, 1991. In addition, Travelers paid claimant's medical bills, in the amount of \$646.15, for services attributable to treatment of his knees. These expenses totalled \$18,819.80.

On July 30, 1992, Travelers petitioned the Board for resolution of a dispute arising from the distribution of proceeds of claimant's recovery obtained in his District Court judgment. Travelers contended that claimant's compensable injury had been exacerbated as a result of the November 1989 motor vehicle accident and that its entire "current lien" of \$18,819.80 was reimbursable from the third party judgment.

Travelers also asserted a future lien, to include future vocational and medical expenses, in addition to any additional permanent or temporary disability benefits to be paid on claimant's knee claim. Noting that claimant's aggravation claim remained in open status, Travelers requested that the Board direct claimant's counsel to hold the balance of any settlement proceeds in trust until such time as a final determination regarding the extent of claimant's permanent disability could be achieved.

In response, claimant argued that Travelers is not entitled to receive reimbursement for its costs. Claimant contended that the costs incurred by Travelers are due entirely to the compensable condition.

CONCLUSIONS OF LAW

As a preliminary matter, claimant moves to strike Travelers' reply to claimant's response to the July 30, 1992 petition for third party distribution. We agree with claimant that Travelers' reply was filed more than 14 days from the date of mailing of claimant's response. See OAR 438-11-020(2). Accordingly, we conduct our review without consideration of Travelers' reply.

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, the 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 (1991); Mary E. Bigler, 44 Van Natta 752 (1992).

Here, Travelers contends that it is entitled to recover temporary disability benefits paid to claimant after the November 8, 1989 motor vehicle accident. Travelers has also paid for medical bills for claimant's bilateral knee condition treatment subsequent to the auto accident. Finally, Travelers asserts a future lien of an undetermined value, to include expenditures for vocational services, in addition to any further permanent and temporary disability and medical services paid for claimant's knee condition. Claimant, however, disagrees that Travelers is entitled to any reimbursement. Claimant contends that the costs Travelers has incurred subsequent to the auto accident are attributable to the compensable injury, rather than the accident. We disagree.

In Mary E. Bigler, *supra*, the claimant had continued to receive chiropractic care for her compensable back condition. At the time of the off-the-job auto accident, she was still under lifting restrictions and she was receiving treatment on a weekly basis. In Bigler, the auto accident worsened claimant's compensable condition and she was eventually taken off work. The claimant's physician was able to distinguish between the disability attributable to the compensable injury and that attributable to the motor vehicle accident. A Referee's order set aside the insurer's denial of claimant's aggravation claim and found that claimant's work remained a material contributing cause of her worsened condition. Consequently, we found that the paying agency was entitled to receive a share of the settlement proceeds in reimbursement.

We find that the facts in the present case are similar to those in Bigler. Here, as in Bigler, a prior, final litigation order has found that the auto accident worsened claimant's compensable condition. As a result of claimant's worsened condition following the motor vehicle accident, Travelers paid temporary disability payments to claimant. Travelers also paid medical costs for claimant's knees following the auto accident.

Claimant, however, contends that the \$200,000 he received as a judgment for the auto accident was intended to cover only the injuries sustained in that accident. Claimant argues that he has made no claim for permanent injury as the result of his auto accident. Claimant also contends that he has made no claim against Travelers for future surgery or temporary disability benefits through August 6, 1990, the date upon which he was found to be medically stationary by the Orthopaedic Consultants. Finally, claimant argues that Travelers never asserted its lien to the federal court jury and the jury made no award for any permanent injury to the knees and no allowance for any future medical care.

At the outset, we conclude that, even if claimant did not argue before the jury that the auto accident caused permanent injury to his knees, claimant also apparently argued that the auto accident did cause knee pain. See Plaintiff's Trial Memorandum at pg. 6. Moreover, there is no evidence that, for purposes of the award, the judgment expressly distinguished between damages awarded for different body parts injured in the accident, some of which were compensable and some which were not. See e.g. Clifford S. Brush, 44 Van Natta 954 (1992) (The award provided for damages related to claimant's (compensable) wrist and knee injuries; however, a judge expressly found that the claimant's (noncompensable) disc injury was not caused by the accident.) Under the circumstances, we are unable to agree with claimant's contention that "no recovery for damages to the claimant's knees" was sought from the jury.

Furthermore, we are not persuaded by the remainder of claimant's argument, which is essentially premised upon his contention that any expenses incurred by Travelers subsequent to the auto accident are entirely attributable to the compensable knee condition, rather than to an injury sustained in the noncompensable accident. Here, as in Bigler, *supra*, claimant's compensable bilateral knee condition claim was reopened as a result of a Referee's order. Moreover, a Board order affirmed the Referee on the issue of aggravation. In doing so, the Board expressly found that claimant's bilateral knee condition was medically stationary prior to the auto accident. In addition, the Board relied upon

the medical evidence and claimant's credible testimony to find that, following the motor vehicle accident, claimant's knee condition had worsened.

Under the circumstances, we find that claimant was medically stationary prior to the motor vehicle accident, and the accident resulted in a reopening of claimant's claim. Furthermore, the medical evidence supports Travelers' contention that claimant's bilateral knee condition was worsened by the motor vehicle accident. On January 10, 1992, Dr. DiPaola, claimant's treating physician following the motor vehicle accident, agreed that the major reason claimant was off work (with respect to his knee condition after November 1989) was the motor vehicle accident, rather than the compensable industrial injury. Ex. 60. Accordingly, the motor vehicle accident triggered Travelers' duty to pay benefits which it ordinarily would not have been required to provide. Consequently, we are not persuaded by claimant's argument that Travelers' expenses following the accident were due to the compensable injury.

Moreover, in the present case, claimant has accepted benefits as a result of prevailing upon his aggravation claim. See Verne E. Davis, 43 Van Natta 1726 (1991)(Benefits paid as a result of the reopening of a claim satisfy the definition of compensation pursuant to ORS 656.593(1)(c), and, because the insurer is statutorily obligated to provide compensation such as temporary and permanent disability benefits, it may recover such benefits from a third party recovery.) Therefore, although claimant argues that he has made no claim for permanent injury, future surgery or temporary disability benefits for his bilateral knee condition subsequent to August 1990, Travelers is nonetheless statutorily required to provide benefits as a result of the reopening of the aggravation claim, and it may recover those benefits from a third party recovery.

Claimant has also alternatively argued that Travelers' overpayment of temporary disability benefits paid after his August 6, 1990 medically stationary date may only be recovered as an offset against future compensation and not from his third party recovery. We disagree.

As noted above, Travelers was required to pay temporary disability benefits on claimant's knee claim. We have above found that such benefits were paid as a direct result of the noncompensable motor vehicle accident and constituted costs paid as a result of the reopening of claimant's claim. Therefore, Travelers, as paying agency, is entitled to recover reimbursement for such costs attributable to temporary disability benefits paid as a result of that reopening. See Verne E. Davis, *supra*. Such a conclusion also does not preclude Travelers from offsetting this overpayment against claimant's future permanent disability if authorized pursuant to ORS 656.268(13).

Claimant's final objection to Travelers' petition is that the auto accident relieved Travelers of its responsibility for paying the cost of an authorized vocational rehabilitation program. Claimant contends that, if it were not for the motor vehicle accident, Travelers would have been required to pay for claimant's vocational services.

Inasmuch as claimant continues to have a compensable claim, it cannot be said that Travelers has been relieved of its statutory duty to provide vocational assistance under ORS 656.340. Furthermore, we decline to speculate whether future vocational services will be entirely due to claimant's additional injuries incurred in the auto accident. Consequently, we reject claimant's assertion that Travelers is precluded from asserting a future lien for vocational services expenditures. Nevertheless, for the reasons discussed below, a determination concerning the amount, if any, of that lien which may be recovered from the third party judgment must be postponed until the aggravation claim is finally determined.

In conclusion, we hold that the November 1989 auto accident required Travelers to provide additional compensation that it would not have otherwise paid. We further find that the record establishes that Travelers expended \$18,819.80 in temporary disability benefits and medical services which were directly attributable to the motor vehicle accident.

Travelers is, therefore, entitled to recover \$18,819.80 from the third party judgment. Claimant's attorney is directed to distribute the proceeds in accordance with ORS 656.593(1). Specifically, following allocation for claimant's attorney fee and litigation costs, claimant shall receive 1/3 of the remaining balance. ORS 656.593(1)(a), (b). Thereafter, Travelers shall receive \$18,819.80. ORS 656.593(1)(c).

Because there has not been a final order determining the issue of premature closure and the extent of claimant's disability arising out of his aggravation claim, it is appropriate to defer ruling on the question of the paying agency's entitlement to a lien for anticipated future expenditures, as well as any permanent disability resulting from the motor vehicle accident. See Ray Littlefield, 41 Van Natta 1781 (1989); John C. Adams, 40 Van Natta 1794 (1988).

Accordingly, the remaining balance of the proceeds shall be held by claimant's attorney in trust pending a final determination concerning the issues of premature closure and extent of permanent disability, which are currently pending before the Hearings Division. Upon final resolution of the premature closure and extent of permanent disability issues, and assuming a dispute continues to exist, the parties shall notify the Board of their respective positions. Thereafter, the Board will proceed to resolve the dispute.

IT IS SO ORDERED.

October 22, 1992

Cite as 44 Van Natta 2144 (1992)

In the Matter of the Compensation of
MINDI M. MILLER, Claimant
WCB Case No. 91-03072
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

On August 24, 1992, we issued an Order on Review in which we affirmed a Referee's order that declined to award a carrier-paid attorney fee for prevailing on a null aggravation denial. We did not address the issue of temporary disability benefits. Thereafter, the insurer moved for reconsideration. It noted that our order did not address the issue of temporary disability benefits, an issue it raised in its cross-request for Board review. We note that the insurer timely cross-requested Board review of the temporary disability issue; however, we also note that its respondent/cross-appellant's brief was rejected as untimely. Therefore, we do not consider that brief in addressing the issue raised by the insurer's cross-request.

On September 21, 1992, we withdrew our order for reconsideration. Claimant was granted ten days within which to respond. Inasmuch as that 10-day period has expired and no such response has been received, we proceed with our reconsideration.

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 first paragraph.

Claimant was released to modified work and earned her regular wage from August 18, 1990 through September 4, 1990 while performing modified work for the at-injury employer. On September 5, 1990, claimant went to the Emergency Room of the McKenzie-Willamette Hospital for treatment of bilateral wrist pain. (Exs. 12, 13). Dr. Waugh, a physician working in the Emergency Room, released claimant from work for a period of five days. Id. Following Dr. Waugh's release, claimant did not return to work.

Claimant's claim was closed by a Determination Order on June 11, 1991 which awarded temporary partial disability from August 18, 1990 through December 28, 1990. (Ex. 46). It awarded no temporary total disability or permanent disability. The insurer paid no temporary disability to claimant prior to or following claim closure.

On March 13, 1991, claimant requested a hearing and listed temporary partial disability and temporary total disability among the reasons for the hearing request. At the October 22, 1991 hearing, the only issue regarding temporary disability was a request by claimant that the insurer pay the temporary partial disability as awarded by the June 11, 1991 Determination Order. As of the

October 22, 1991 hearing, neither the insurer nor claimant had requested reconsideration of the Determination Order.

Jurisdiction

Here, a Determination Order issued which awarded only temporary partial disability. The insurer did not pay this award. Claimant requested a hearing raising the insurer's nonpayment as an issue. (Tr. 4). The insurer raised no cross-issues at hearing and argued that the Referee did not have jurisdiction over the temporary disability issue because no request for reconsideration of the Determination Order had been made. We agree with the Referee's decision that he had jurisdiction.

ORS 656.268(5) provides, in relevant part, that "[i]f the worker, the insurer or self-insured employer objects to a determination order issued by the department, the objecting party must first request reconsideration of the order." This request for reconsideration must be received by the Department within 180 days from the mailing date of the Determination Order. Former OAR 436-30-050. Thereafter, if any party objects to the reconsideration order, the party may request a hearing pursuant to ORS 656.283 within 180 days after the Determination Order is mailed. ORS 656.268(6)(b).

Here, claimant did not object to the Determination Order. Instead, she asserted that the insurer should pay the temporary partial disability awarded by the Determination Order. In effect, claimant was seeking enforcement of the Determination Order. Thus, under the facts of this case, a reconsideration of the Determination Order need not be made before jurisdiction will pass to the Hearings Division. Compare Lorna D. Hilderbrand, 43 Van Natta 2721 (1991).

Temporary Disability

The Referee addressed the merits of the temporary disability issue and found that: (1) claimant left her modified work due to her compensable injury; (2) the insurer had not subsequently made a written modified job offer pursuant to ORS 656.268(3)(c) which would enable it to terminate payment of temporary disability; and (3) claimant was entitled to "temporary disability" from September 5, 1990 through December 28, 1990. In effect, the Referee found that claimant was not able to work after September 4, 1990 and awarded temporary total disability from that date, without explicitly identifying it as such.

As noted above, because the reconsideration process was not followed here, the Board and the Hearings Division have jurisdiction regarding the issue of temporary disability only as it relates to the enforcement of the Determination Order. When a party objects to a Determination Order, that party must first request a reconsideration of that Determination Order. ORS 656.268(5). That was not done here; therefore, the Referee had no jurisdiction to address the merits of the temporary disability issue. See Lorna D. Hilderbrand, *supra*. In other words, claimant had a right to request a hearing to have the Determination Order enforced and the Referee had the authority to "enforce" the Determination Order. However, the Referee had no authority to modify the Determination Order.

Regarding enforcement of the Determination Order, claimant is entitled to temporary partial disability from August 18, 1990 through December 28, 1990, as awarded by the Determination Order. This award is to be paid pursuant to the rule regarding payment of temporary partial disability in effect at the time of the Determination Order. Former OAR 436-60-030.

Pursuant to former OAR 436-60-030(1), the amount of temporary partial disability compensation is calculated using post-injury earnings. Claimant asserted that she had no post-injury earnings. Therefore, she argued that she is entitled to temporary partial disability at the "full rate." That argument is based on an incorrect assertion. Claimant had post-injury earnings. She returned to modified work on August 15, 1990 after her August 14, 1990 compensable injury and earned her regular at-injury wages. (Ex. 6). Under those circumstances, temporary partial disability benefits are not due. Former OAR 436-60-030(2).

Claimant is arguing, in effect, that she is entitled to temporary total disability because she had no earnings after Dr. Vaughn released her from work on September 5, 1990. However, this is an argument which should have been raised either: (1) prior to claim closure as a procedural matter, see

former OAR 436-60-030(3), (4)(a), and Steven V. Bischof, 44 Van Natta 433 (1992); or (2) after claim closure as a substantive matter through the reconsideration process, see generally former OAR 436-30-036(1)-(7); 436-30-050(1) and (2). Since claimant requested this hearing following the Determination Order, she is essentially asserting that the Determination Order should have awarded temporary total disability from September 5, 1990 through December 28, 1990. Such an argument must be initially raised through the reconsideration proceedings set forth in ORS 656.268(5). Because claimant did not request reconsideration of the Determination Order, the Referee was without authority to determine claimant's entitlement to temporary total disability for a period during which the Determination Order awarded temporary partial disability.

As discussed above, claimant's temporary partial disability was set at zero. Once these benefits were calculated, they could not be altered until the occurrence of a medically verified total release from work from the attending physician. See former OAR 436-60-030(4). Such an event may well have occurred. Nevertheless, since claimant's objection to this failure to pay temporary total disability was filed after the issuance of the Determination Order, the appropriate forum to initially consider this matter is the Evaluation Section through a reconsideration proceeding.

Because the Determination Order awarded only temporary partial disability and since such benefits were calculated at zero, it follows that claimant was not entitled to compensation as a result of the Determination Order. Consequently, there are no amounts "then due" nor has there been an unreasonable resistance to the payment of compensation. Accordingly, neither penalties nor attorney fees are warranted.

On reconsideration, as supplemented herein, we republish our August 24, 1992 order. The Referee's order dated November 29, 1991 is affirmed in part and reversed in part. Those portions of the Referee's order which awarded temporary total disability, an out-of-compensation attorney fee, and assessed a penalty under ORS 656.262(10)(a) are reversed. The remainder of the Referee's order is affirmed. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

October 23, 1992

Cite as 44 Van Natta 2146 (1992)

In the Matter of the Compensation of
GERTRUDE V. DRADER, Claimant
 WCB Case No. 90-17057
 ORDER ON REVIEW
 Michael B. Dye, Claimant Attorney
 Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

The self-insured employer requests review of Referee Michael V. Johnson's 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 reverse.

FINDINGS OF FACTS

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

In January 1990, claimant and her husband took a one-month vacation trip to Mexico, traveling approximately 2,000 miles in their motor home. The prolonged sitting while traveling caused an increase in claimant's low back pain.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's low back condition is compensable, finding that the 1987

industrial injury is the major contributing cause of the condition and the resultant need for treatment. We disagree.

We find that claimant has preexisting degenerative disc disease in the low back which combined with the 1987 compensable injury to cause her current need for treatment. Accordingly, claimant has the burden of proving that the compensable injury is the major contributing cause of her need for treatment. See ORS 656.005(7)(a)(B); Bahman M. Nazari, 43 Van Natta 2368, 2370 (1991). Because this issue presents a medically complex question, its resolution turns on the expert medical evidence. See Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

The relevant medical opinions were issued by Dr. Schmidt, claimant's family physician, and Dr. Teal, the attending orthopedic surgeon. Dr. Schmidt was unable to substantiate whether claimant's current condition is related to the compensable injury. (Ex. 14). Indeed, he specifically deferred to the greater expertise of Dr. Teal on this issue.

Dr. Teal issued various opinions on the causation issue. For the following reasons, however, we find Dr. Teal's opinions not to be persuasive.

On March 12, 1990, Dr. Teal opined that claimant's condition is "simply a flare up of her prior on-the-job mishap." (Ex. 4-4). On April 23, 1990, however, Dr. Teal reversed his opinion:

"In my medical opinion, * * * I feel that [claimant's] low back problem is primarily related to extended sitting in a motor home which occurred in January of 1990."

"Indeed, this has nothing to do with her on-the-job activities but indeed was caused by her activities while on vacation." (Ex. 13).

Later that same month, Dr. Teal again reversed his opinion. He concurred with claimant's attorney's letter, which stated that the 1987 compensable injury is and remained the major contributing cause of claimant's current condition and that the Mexico trip could not be considered the major contributing cause of her condition. (Ex. 18).

Dr. Teal's opinion again vacillated during his June 12, 1991 deposition. He testified that degenerative disc disease in the low back will typically become symptomatic with prolonged sitting. (Ex. 19-12). He also testified that, in this case, he could not determine whether claimant's symptoms are due to her degenerative disc disease or the 1987 compensable injury. (Ex. 19-12, 19-13). However, he later testified that he continued to adhere to his earlier opinion (see Ex. 18) that the 1987 compensable injury was the major contributing factor. (Ex. 19-15).

Given the inconsistencies in Dr. Teal's opinion, we do not find it to be persuasive. See, e.g., Jess R. Johnson, 43 Van Natta 2445, 2446 (1991); Dean A. Mintun, 43 Van Natta 1902, 1903 (1991). Moreover, Dr. Teal's opinion in support of compensability is not supported by a persuasive medical analysis. Finally, we note that Dr. Teal appeared to misunderstand the "major contributing cause" standard. During his deposition, he described "major" as meaning "fifty percent or more." (Ex. 19-15). However, we have previously defined "major cause" to mean a causal agent which "contributes more to the onset or worsening than all other [causal agents]." Leo R. Cox, Jr., 43 Van Natta 2354 (1991) (emphasis added).

Accordingly, we conclude that the expert medical evidence does not establish that the 1987 compensable injury is the major contributing cause of claimant's current back condition and resultant need for treatment. Inasmuch as claimant has not sustained her burden of proof, her medical services claim is not compensable.

ORDER

The Referee's order dated December 11, 1991 is reversed. The self-insured employer's denial is reinstated and upheld. The Referee's attorney fee award is also reversed.

In the Matter of the Compensation of
STEVEN E. EDGERLY, Claimant
WCB Case No. 91-12465
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Westerband and Brazeau.

Claimant requests review of Referee Bethlahmy's order that dismissed his 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 an October 16, 1990 Determination Order. We agree.

A request for hearing must be filed within 180 days after the date copies of the Determination Order are 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 Evaluation Section mailed the Determination Order on October 16, 1990. The Department received claimant's request for reconsideration on April 12, 1991, and issued its Order on Reconsideration on August 30, 1991. The time from the mailing of the Determination Order to the date the Department received claimant's request for reconsideration is 177 days. This figure was arrived at by excluding the date of the Determination Order and the date the request for reconsideration was received, in accordance with the last sentence of ORS 656.268(5). See Robert E. Payne Sr., 44 Van Natta 895 (1992). Thus, claimant had but three more days after the August 30, 1991 Order on Reconsideration, (i.e., no later than September 2, 1991), to file a request for hearing. However, inasmuch as September 2, 1991 was a legal holiday, the last day for filing a hearing request was the next business day, September 3, 1991. ORCP 10A; ORS 174.120; Anita L. Clifton, 43 Van Natta 1921 (1991).

Claimant's hearing request was filed on September 4, 1991, the date it was received by the Board. OAR 438-05-046(1). Therefore, the request was untimely.

Claimant argues that his request for hearing was timely. He first contends that the three days of the Labor Day weekend (August 31, September 1 and 2) should be excluded from the time limitation, because he had less than seven days to file an appeal from the August 30, 1991 Order on Reconsideration. He relies on ORCP 10(a), which provides, in part:

"When the period of time prescribed or allowed (without regard to Section C of this rule) is less than 7 days, intermediate Saturdays and legal holidays, including Sundays, shall be excluded in the computation." (Emphasis supplied.)

Claimant misreads the rule. ORS 656.268(6)(b) expressly provides that a party has 180 days after the mailing of the Determination Order within which to request a hearing. Claimant was advised of this time limitation in the October 16, 1990 Determination Order, as well as in the August 30, 1991 Order on Reconsideration. The fact that he had only three days to request a hearing after the issuance of the Order on Reconsideration was due to claimant's waiting 177 days to request reconsideration, not from a "period of time prescribed or allowed" as provided by statute.

Claimant next argues that, because the Order on Reconsideration was mailed to him, he was entitled to three additional days to the prescribed limitation period in which to request a hearing. He relies on ORCP 10(c), which provides:

"Except for service of summons, whenever a party has the right or is required to do some act or take some proceedings within a prescribed period after the service of a notice or other paper upon such party and the notice or paper is served by mail, three days shall be added to the prescribed period." (Emphasis supplied.)

Again, claimant misreads the rule. ORS 656.268(6)(b) does not require a party to request a hearing within 180 days after service of a Determination Order, but rather within that time period after its mailing. Accordingly, ORCP 10(c) does not apply.

Claimant also argues that the Order on Reconsideration did not comply with OAR 438-05-065, because it was not delivered by certified mail or personally served. As noted by the employer, OAR 438-05-038 is a Board rule and, consequently, does not govern actions of the Department of Insurance and Finance.

Claimant finally argues that a finding that his request for hearing was untimely would violate standards of due process. We acknowledge our authority to decide constitutional questions. See Nutbrown v. Munn, 311 Or 328 (1991); Gerardo Velasquez, 43 Van Natta 1692 (1991). We are not persuaded by claimant's argument, however, and decline to address it.

ORDER

The Referee's order dated February 18, 1992 is affirmed.

October 23, 1992

Cite as 44 Van Natta 2149 (1992)

In the Matter of the Compensation of
GERALD L. HOWE, Claimant
WCB Case No. 90-21127
ORDER ON REVIEW
Ainsworth, et al., Claimant Attorneys
Norm Cole (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Westerband.

Claimant requests review of that portion of Referee Brown's order that upheld the SAIF Corporation's denial of claimant's pulmonary condition. On review, the issue is compensability.

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

The Referee found that claimant's pulmonary condition and dyspnea was not related to his compensable injury. We agree.

The medical evidence indicates that claimant suffers from preexisting emphysema which combined with his compensable chest injury to produce disability and a need for treatment. Accordingly, this case is analyzed under ORS 656.005(7)(a)(B). We have construed this statute as requiring a two-step determination. See Bahman M. Nazari, 43 Van Natta 2368 (1991). First, claimant must prove that the industrial injury is a material contributing cause of disability or need for treatment; second, claimant must prove that the compensable injury is the major contributing cause of his disability or need for treatment. Id.

After reviewing the medical evidence, we agree with the Referee that Dr. Smith's opinion is more persuasive than that of Dr. Marx. See Somers v. SAIF, 77 Or App 259 (1986). Smith concluded that claimant's emphysema, not the compensable injury, is the major contributing cause of his

pulmonary condition. Accordingly, we agree with the Referee that claimant has not proven that his pulmonary condition or resulting dyspnea is compensable.

ORDER

The Referee's order dated January 9, 1992 is affirmed.

October 23, 1992

Cite as 44 Van Natta 2150 (1992)

In the Matter of the Compensation of
MELISSA ORTADO, Claimant
 WCB Case No. 91-14613
 ORDER ON REVIEW
 Westmoreland & Shebley, Claimant Attorneys
 Cooney, et al., Defense Attorneys

Reviewed by Board Members Westerband and Brazeau.

Claimant requests review of Referee Neal's order that dismissed claimant's hearing request for lack of jurisdiction. On review, the issue is jurisdiction.

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

The issue presented in this case is whether the Hearings Division has initial jurisdiction over a dispute regarding claimant's entitlement to what the insurer believes is palliative care. After our review, we agree with the Referee that the resolution of that issue is controlled by our prior decisions in Stanley Meyers, 43 Van Natta 2643 (1991), and Robert D. Cox, 43 Van Natta 2726 (1991), in which we held that original jurisdiction over disputes regarding the appropriateness of medical care lies exclusively with the Director. We add, however, that nothing in either of those decisions has modified the insurer's duty to process the claim under ORS 656.262(1). Thus, the insurer must either pay claimant's medical bills or seek Director review of two questions: (1) whether the treatment was curative or palliative Gladys M. Theodore, 44 Van Natta 905 (1992); and (2) if curative, whether it is reasonable and necessary. Unless the insurer timely initiates Director review, it risks the imposition of penalties or attorney fees. ORS 656.262(10) and ORS 656.382.

ORDER

The Referee's order dated January 23, 1992 is affirmed.

October 23, 1992

Cite as 44 Van Natta 2150 (1992)

In the Matter of the Compensation of
DONNA E. PUGLIESI, Claimant
 WCB Case No. 91-13174
 ORDER ON REVIEW
 Richard F. McGinty, Claimant Attorney
 Bonnie V. Laux (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Nichols' order which upheld the SAIF Corporation's denial of her occupational disease claim for a bilateral carpal tunnel condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the last sentence.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had failed to prove that she suffered a compensable occupational disease. We disagree.

Claimant has the burden to prove that her employment conditions were the major contributing cause of the disease or its worsening. In addition, the existence of the disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings. ORS 656.802(2). A "major contributing cause" means an activity or exposure or combination of activities or exposures which contributes more to the onset of the condition than all other activities or exposures combined. See Dethlefs v. Hyster Co., 295 Or 298 (1983).

The existence of claimant's bilateral carpal tunnel syndrome is supported by objective findings. Electrophysiologic tests show slowing of both median nerves. In addition, Dr. Heder noted positive Tinel's signs and symptoms of intermittent numbness and tingling in both hands.

Two physicians address the causation of claimant's carpal tunnel syndrome. Claimant's attending physician, Dr. Heder opined that claimant's carpal tunnel syndrome resulted from her work activities. Dr. Nathan, who saw claimant in an independent medical examination, confirmed that claimant had carpal tunnel syndrome, but opined that claimant's carpal tunnel syndrome resulted from an intrinsic process and would have developed regardless of her employment.

We find Dr. Nathan's opinion that an "extrinsic process" caused claimant's carpal tunnel syndrome to be conclusory and lacking in analysis and explanation. Therefore, we find his opinion unpersuasive. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980). On the other hand, Dr. Heder could find no off-work causes for claimant's carpal tunnel condition, but related it to claimant's work as a costume assistant. Dr. Heder is the treating physician and we find no persuasive reasons not to defer to his opinion regarding causation. Weiland v. SAIF, 64 Or App 810 (1983).

In rendering his opinion, Dr. Heder did not quantify the degree of causation by indicating that the work exposure was the major contributing cause of the carpal tunnel syndrome. However, the use of "magic words" or statutory language is not required. Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991); McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986). Based on the record as a whole, we find that claimant has established a compensable occupational disease.

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 \$3,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 15, 1992 is reversed. The SAIF Corporation's denial of claimant's bilateral carpal tunnel syndrome is set aside and the claim remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded \$3,000 to be paid by SAIF.

In the Matter of the Compensation of
MARIE M. SAX, Claimant
WCB Case No. 91-06036
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Foss, et al., Defense Attorneys

Reviewed by Board Members Gunn and Brazeau.

Claimant requests review of Referee Quillinan's order that upheld the insurer's denial of her aggravation claim for a right knee condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, except the "Ultimate Findings" and the last two sentences of the seventh paragraph on page two, with the following supplementation.

ULTIMATE FINDINGS OF FACT

Claimant's 1988 compensable right knee injury is the major contributing cause of her current right knee condition. Claimant's compensable right knee condition symptomatically worsened, since the October 31, 1988 Notice of Closure, diminishing her earning capacity. Claimant's worsened right knee symptoms are established by medical evidence supported by objective findings.

CONCLUSIONS OF LAW AND OPINION

The Referee upheld the insurer's denial of claimant's aggravation claim, because she found that claimant's 1988 work injury is not the major cause of the claimed current right knee condition. ORS 656.005(7)(a)(B). We conclude that claimant has carried her burden. However, we analyze the causation element of this claim under ORS 656.005(7)(a)(A) rather than ORS 656.005(7)(a)(B).

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). The worsening must be established by medical evidence supported by objective findings. ORS 656.273(3).

An aggravation has two components: causation and worsening. See Thomas L. Fitzpatrick, 44 Van Natta 877 (1992). Both must be established, unless one is conceded. Here, because both elements of the aggravation claim are challenged, (see Ex. 25), we first consider whether claimant has carried her burden concerning causation. If she has, we next consider whether her compensable right knee condition has worsened since the last arrangement of compensation, an October 1988 Notice of Closure which awarded no permanent partial disability compensation. See Thomas L. Fitzpatrick, supra; Bertha M. Gray, 44 Van Natta 810 (1992).

Claimant argues that, because she suffered two compensable right knee injuries, a rebuttable presumption arises that the last injury independently contributed to the current worsened condition. See Industrial Indemnity Company v. Kearns, 70 Or App 583 (1984). However, the "Kearns presumption" would not be applicable here, for this case involves compensability, rather than responsibility.

Nevertheless, we have concluded that where an insurer did not give notice of its intent to disclaim responsibility for a worker's condition on the basis of exposure with another employer, it is precluded from defending against this claim on the basis of that exposure. See Richard F. Howarth, 44 Van Natta 1531 (1992) (citing ORS 656.308(2)).

In the present case, the insurer did not timely notify claimant of its intent to disclaim responsibility on the basis of claimant's prior work exposure. See ORS 656.308(2). Under these circumstances, the 1977 compensable injury is not a "preexisting disease or condition" for purposes of

the compensability analysis under ORS 656.005(7)(a)(B). See Richard F. Howarth, *supra*. Therefore, in determining whether claimant's current right knee condition is compensable, the causal contribution of the 1977 work injury is not weighed against the contribution of the 1988 injury.

Treating and examining physicians agree that causal factors contributing to claimant's current right knee problems include the 1977 and 1988 work injuries, degenerative changes associated with obesity and both injuries, wear and tear of everyday living, and claimant's substantial weight gain since the 1988 injury. (See Exs. 32-1, 39-13). Although some of these factors may have impacted claimant's knees for years, (see e.g., Exs. 1-2, 2-1), there is no indication that claimant had a preexisting right knee "disease or condition," within the meaning of ORS 656.005(7)(a)(B). In the absence of such evidence, there is no "resultant condition" and ORS 656.005(7)(a)(B) is inapplicable.

On the other hand, the medical evidence documents the development of claimant's right knee degeneration following her compensable injuries. Dr. Smith's uncontradicted diagnosis establishes that claimant currently suffers from an acute meniscal tear with degenerative changes. (Ex. 39-14). It is not clear exactly when the tear occurred. However, it is undisputed that the extent of the tear is due in part to post-injury degeneration. Under these circumstances, claimant must establish that her current condition arose as a consequence of her compensable injury. ORS 656.005(7)(a)(A). Thus, she must prove that her 1988 compensable injury is the major contributing cause of the allegedly consequential right knee condition. See Julie K. Gasperino, 43 Van Natta 1151 (1991), *aff'd* Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

We find the necessary causal relationship established by the opinion of Dr. Smith, who treated claimant after both right knee injuries. Smith acknowledged the interrelationship between several causes contributing to claimant's current right knee problems, including the 1977 and 1988 compensable injuries. He also noted that claimant's obesity puts added stress on her knee, which may speed up degeneration and slow down healing. (Ex. 39-14). Smith opined that no "one factor" is the primary cause of claimant's knee problems. (Ex. 39-23-24). Instead, Smith pointed out that all factors, except the injuries, have affected both knees equally.

Inasmuch as claimant has only right knee problems, Smith concluded that the injuries are important causal factors. Without them, Smith suspected that claimant's knees would be very similar. (Exs. 39-17, 39-25). Under such circumstances, we conclude that Smith's opinion supports a finding that the 1988 injury is the major cause of claimant's current right knee condition. This conclusion is further supported by the opinions of Drs. Jones, Bert and Gurney, which we consider to be consistent with Smith's reasoning and conclusions. (See Exs. 26, 26B, 27, 29).

The Medical Consultants Northwest, independent examiners, opined that the 1977 and 1988 injuries contribute "less than 51 percent" to claimant's present complaints. (Ex. 23-5, see also Ex. 38). Considering the conclusory nature of that opinion and Smith's advantage as treating physician, we conclude that the Consultants do not effectively rebut Smith's reasoning and conclusions. On this evidence, we conclude that claimant's 1988 work injury is the major cause of her current disability and need for treatment for her right knee.

In addition, we conclude that claimant has proven at least a symptomatic worsening since the October 31, 1988 Notice of Closure and that this worsening is established by medical evidence supported by objective findings. In this regard, we are persuaded by Dr. Bert's September 20, 1991 chart note acknowledging claimant's increased pain complaints. (See Ex. 13a). We further conclude that, since claimant's claim was closed without a permanent disability award, claimant's worsened right knee symptoms caused diminished earning capacity. (See Ex. 36). Accordingly, claimant has proven her aggravation claim. See ORS 656.273; Robert E. Leatherman, 43 Van Natta 1677 (1991).

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's denial. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review 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 November 26, 1991 is reversed. The insurer's denial is set aside and the claim is remanded to it 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.

October 23, 1992

Cite as 44 Van Natta 2154 (1992)

In the Matter of the Compensation of
MARY E. WILLIAMS, Claimant
WCB Case No. 87-00078
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
John Motley (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Holtan's order that: (1) found that claimant's neck and right shoulder injury claim was not prematurely closed; (2) authorized the SAIF Corporation to offset temporary disability compensation paid for periods after claimant's February 21, 1986 medically stationary date; and (3) affirmed a Determination Order award of 10 percent (32 degrees) unscheduled permanent partial disability. On review, the issues are premature closure, temporary disability, offset or, alternatively, extent of unscheduled permanent partial disability and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINIONPremature closure/temporary disability/offset

The Referee found that claimant's August 10, 1984 injury claim was not prematurely closed, that claimant was medically stationary on February 21, 1986 and that her substantive entitlement to temporary disability compensation ended on that date. The Referee also found that an October 27, 1986 Determination Order properly closed the claim and that claimant's procedural entitlement to temporary disability compensation ended when the order issued. Accordingly, the Referee authorized offset of temporary disability compensation paid for periods after the February 21, 1986 medically stationary date against claimant's permanent disability award.

Claimant argues that Dr. Bolin's opinion regarding claimant's medically stationary status is unpersuasive, because Bolin did not reference the August 10, 1984 injury which is the basis for the current claim. However, even discounting that opinion due to Bolin's apparent incomplete history, we conclude that claimant has not carried her burden of proving that her claim was prematurely closed.

A claim may be closed if claimant's compensable condition is medically stationary, i.e., no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). It is claimant's burden to establish that she was not medically stationary when the claim was closed. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The reasonableness of medical expectations for claimant's condition must be judged in the context of the condition at the time of closure. Scheuning v. I.R. Simplot, 84 Or App 622, rev den 303 Or 590 (1987); Alvarez v. GAB Business Services, 72 Or App 524, 527 (1985). Subsequent testimony, opinions or events may only be considered to the extent that they relate to claimant's condition at the time of closure. Wojick v. Weyerhaeuser, 89 Or App 561 (1988); Scheuning, supra.

On October 30, 1985, Dr. Kelley, former treating chiropractor, referred claimant to Dr. Carlson for continuing manipulative care in Washington. (Ex. 17). On November 4, 1986, Kelley opined that, as of his last examination, claimant had permanent disability due to her cervical/right upper extremity

condition. He characterized that condition as "very chronic," (Ex. 18), and did not predict that it would improve. On February 21, 1986, Dr. Bolin, independent chiropractor, examined claimant and opined that she "has fully recovered from her injuries with minimal residuals." (Ex. 21-3).

On October 8, 1986, Dr. Carlson, current treating chiropractor, suspected that claimant was "perhaps medically stationary." (Ex. 25-1). Carlson recommended continuing supportive care and referred claimant to Dr. Steele, a chiropractor who specializes in a "different method of cervical correction, for a 6 week trial, before final determination is made[.]" (Ex. 25-2). Carlson could not "objectively see why [claimant's] neck shouldn't progress substantially further." (Id).

An October 27, 1986 Determination Order closed the claim, listed February 21, 1986 as claimant's medically stationary date and awarded 10 percent unscheduled permanent partial disability. (Ex. 24).

On September 15, 1987, Carlson opined, without explanation, that claimant's neck and shoulder condition was medically stationary on November 5, 1986, but not before. (Ex. 33).

We read Carlson's comment that he could not see why claimant's neck should not progress further in conjunction with his contemporaneous referral to chiropractor Steele. In that context, we believe that Carlson had no more treatment to offer and that he hoped, but not necessarily anticipated, that Steele could help claimant. Moreover, because Carlson last examined claimant on October 8, 1986, there is no factual basis for his opinion that claimant became medically stationary on November 5, 1986. Furthermore, Carlson offers no explanation for his September, 1987 certainty regarding his expectations for improvement on November 5, 1986. In our view, Carlson's opinion lacks both persuasive reasoning and a reliable factual basis to judge its validity. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980). Consequently, the opinion is unpersuasive and we do not rely on it. See Somers v. SAIF, 77 Or App 259 (1986).

In sum, we find no persuasive evidence supporting claimant's contention that there was a reasonable expectation of material improvement in the compensable condition when the October 27, 1986 Determination Order closed the claim. Accordingly, we agree with the Referee's conclusion that the claim was not prematurely closed.

Claimant does not assert entitlement to temporary disability benefits or object to authorization of offset on any basis other than premature closure. Therefore, inasmuch as claimant became medically stationary on February 21, 1986, her entitlement to temporary disability compensation ended on that date. Because SAIF continued to pay temporary disability benefits thereafter, an overpayment was created. See Fazzolari v. United Beer Dist., 91 Or App 592, adhered to 93 Or App 103, rev den 307 Or 236 (1988). Under these circumstances, SAIF's overpayment may be offset. See former ORS 656.268(10).

Extent of unscheduled permanent disability and attorney fees

We adopt the Referee's opinion on these issues.

ORDER

The Referee's order dated January 31, 1992 is affirmed.

In the Matter of the Compensation of
RICHARD H. WILLWORTH, Claimant
WCB Case Nos. 91-15077 & 91-15078
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Janice Pilkenton, Defense Attorney
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

United Pacific Insurance Company (United) requests review of Referee Spangler's order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) upheld Safeco Insurance Company's denial of a "new injury" claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. United denied both responsibility and compensability of claimant's low back condition. (Ex. 27). As a result, the Director did not designate a paying agent for the processing of claimant's low back claim. (Ex. 31).

CONCLUSIONS OF LAW AND OPINION

Responsibility

Claimant worked for the same employer during the time in question. On November 30, 1990, claimant sustained a compensable low back injury in a lifting incident. United accepted that injury, and claimant's claim was closed on February 11, 1991 with an award of temporary disability only. (Ex. 16). Prior to July 24, 1992, the employer became insured by Safeco. On July 24, 1992, claimant suffered increased low back symptoms following a lifting incident at work.

The Referee found that responsibility remained with United because it had not established that a new injury had occurred while Safeco was at risk. We agree.

ORS 656.308(1) states the law regarding responsibility. 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, United, as the last insured against whom claimant had an accepted low back injury, remains presumptively responsible. In order to avoid responsibility, United has the burden of establishing that claimant sustained a new compensable injury involving the same condition while Safeco was at risk.

Claimant credibly testified that the November 1990 injury was more severe than the July 1991 lifting incident in that it caused greater pain and required more time to stabilize. (Tr. 20, 28). He also testified that, although the pain was less severe following the July 1991 incident, it occurred in the same area of his low back and was the same type of sharp, shooting pain. (Tr. 20, 22). Following the November 1990 injury, claimant was able to perform his work, although he had "good days and bad days," depending on his level of activity. (Tr. 29). Following the July 1991 incident, claimant returned to that level. (Tr. 24).

Thus, claimant's testimony suggests that he did not suffer a new injury, but had only increased symptoms from his November 1990 compensable injury. See Taylor v. Mult. School District, 109 Or App 499 (1991); Gerald K. Mael, 44 Van Natta 1481 (1992). Although claimant's testimony 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. Ferguson, treating M.D., Dr. Cannard, treating chiropractor, Dr. Simpson, chiropractor, and Dr. Dinneen, orthopedist. The latter two doctors are employed by Western Medical Consultants, Inc. and performed an independent medical examination on October 30, 1991.

Drs. Simpson and Dinneen opined that claimant's "acute episodes" were "independent and unrelated events" and his recurring need for treatment was related to these separate events. (Ex. 34-4). They also stated that they disagreed with the opinion of Dr. Ferguson, treating physician, that claimant's condition following the July 1991 incident was causally related to the November 1990 injury. We do not find their opinion persuasive because it is both conclusory and based on an examination not following the November 1990 injury.

Dr. Cannard first treated claimant following the July 1991 incident. He opined, based on his clinical observations, that the July 1991 incident was a material cause of claimant's condition. (Ex. 33). However, Dr. Cannard acknowledged that he was unable to give an opinion as to the affect of prior incidents on claimant's condition because he had not previously treated claimant. (Exs. 29, 33). Thus, Dr. Cannard's opinion fails to consider the affect of the November 1990 compensable injury. Furthermore, like Drs. Simpson and Dinneen, Dr. Cannard has no basis for comparing the two events. For these reasons, we do not find Dr. Cannard's opinion persuasive.

Dr. Ferguson treated claimant after both the November 1990 injury and the July 1991 lifting incident. He consistently stated that the November 1990 injury was the major contributing cause of claimant's condition in July 1991. (Exs. 26, 32, 35, 36). He also noted that it was common for claimant to achieve recovery and normal activity, but that claimant could expect future exacerbations of his back condition. (Ex. 32).

On the other hand, Dr. Ferguson also agreed with United's December 27, 1991 letter in which it stated that the July 1991 lifting incident is a material or substantial contributing contributing of claimant's need for medical treatment and/or disability. (Ex. 36). United argues that that agreement establishes that a new injury occurred in July 1991. We disagree.

Dr. Ferguson's chart notes and his reports support claimant's credible testimony that he had continuing symptoms following the November 1990 injury with symptomatic exacerbations following physical exertion. Based on this, we find that Dr. Ferguson's opinions as a whole do not support an "actual, independent, compensable injury" in July 1991, but rather support a conclusion that claimant experienced a symptomatic exacerbation of his November 1990 compensable condition which, following conservative treatment, returned to his post-November 1990 "baseline." Under such circumstances, we are persuaded that claimant sustained an aggravation of his November 1990 compensable injury.

Accordingly, because the evidence does not establish that claimant suffered a new compensable injury while Safeco was at risk, United, as the carrier against whom claimant has an accepted low back injury, remains responsible for future compensable medical services and disability relating to that condition. ORS 656.308(1).

Attorney Fee on Review

United's denial had contested compensability and no ".307" order was issued. Furthermore, compensability was an issue at hearing. Therefore, by virtue of the Board's de novo review authority, compensability remained at risk on review as well. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992); 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 Teresi, supra; 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 United. 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 February 26, 1992 is affirmed. For services on review, claimant's attorney is awarded \$500, to be paid directly to claimant's attorney by United Pacific Insurance Company.

In the Matter of the Compensation of
JACK W. NETHERCOTT, Claimant
WCB Case No. 91-09935
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
David Lillig (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Bethlahmy's order that upheld the SAIF Corporation'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

Claimant objects to the Referee's conclusion that he failed to prove a worsening of his condition. Claimant contends that, based on his own testimony of increased symptoms and medical evidence showing restricted range of motion in his back, he proved a claim for aggravation.

An injured worker is entitled to additional compensation after the last award or arrangement of compensation for worsened conditions resulting from the original injury. ORS 656.273(1). A worsened condition must be established with medical evidence supported by objective findings. *Id.* Therefore, although claimant's testimony indicates that he suffers from increased symptoms compared to his condition at the time of claim closure, he is not entitled to additional compensation under ORS 656.273 without medical evidence supporting his testimony. We find that claimant failed to carry his burden of proof in this regard.

The medical evidence shows that since his January 1990 injury, claimant has experienced constant back pain. (Ex. 7). Claimant's treating physician, Dr. Cockcroft, M.D., diagnosed claimant with a chronic low back syndrome. (Ex. 31). The medical evidence, however, fails to prove that claimant's current symptoms are any greater than they were at the time of the February 1991 claim closure when claimant was awarded 13 percent unscheduled permanent disability.

Although Dr. Cockcroft reported that claimant complained of "attacks of severe back, left lumbar spine going down the left leg causing him to lose strength in the leg and fall," he states only that claimant "has continued to remain disabled and that my attempts at adjusting his leg lengths with shoe lifts, physical therapy and allowing time to heal, have been unsuccessful." (Ex. 32) (emphasis added). In a later report, Cockcroft states that claimant's "back pain has waxed and waned over the 18 month period since his injury." (Ex. 35). We find that these statements indicate that claimant's current symptoms were consistent with those experienced since his injury rather than representing a worsened condition.

That conclusion is supported by statements from Dr. Keizer, orthopedic surgeon, who saw claimant on referral from Dr. Cockcroft. He reported that, since claimant's injury, "he has had pain and discomfort which has been present in his back. I had seen him for that condition after his referral from Dr. Cockcroft." (Ex. 36) (emphasis added). Keizer added that claimant had "an aggravation of his [preexisting] condition with a fall of January 29, 1990, to the point that he was markedly worsened." (*Id.*) Furthermore, Keizer found that claimant was "fit to return to some type of light work with restrictions" and agreed that "he remains medically stationary." (Ex. 40). Again, this evidence demonstrates that claimant's treatment was for his continuing symptoms rather than a worsened condition.

Furthermore, we disagree with claimant that, for the first time since his injury, he has shown restricted range of movement. Although Dr. Keizer documented that claimant could bend forward only to his knees, extend 25 degrees, laterally bend 25 degrees and rotate 35 degrees (Ex. 34), those findings were very similar to ones taken by Dr. Cockcroft a couple of months before claim closure showing that claimant could forward flex only to the thighs, laterally flex approximately 30 degrees and rotate approximately 30 degrees, (Ex. 7-8).

In short, we find that the medical evidence fails to prove a worsened condition. Therefore, we agree with the Referee that claimant failed to establish a claim for aggravation.

ORDER

The Referee's order dated November 15, 1991 is affirmed.

October 26, 1992

Cite as 44 Van Natta 2159 (1992)

In the Matter of the Compensation of
JAMES I. GOODNIGHT, Claimant
WCB Case No. 90-22035
ORDER ON REVIEW
Ronald Somers, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

The SAIF Corporation requests review of that portion of Referee Petersen's order that granted claimant permanent total disability, whereas a Determination Order awarded 74 percent (236.8 degrees) unscheduled permanent disability. On review, the issue is permanent total disability. We affirm.

FINDINGS OF FACT

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

In September 1988, claimant requested assistance from his vocational counselor to follow up on a job lead at a fishery; the counselor believed that the job was inappropriate due to its short duration. In April 1989, claimant followed up on a job lead with a fruit processing plant; the vocational counselor learned that the job would be filled by hiring from within the plant.

Prior to beginning claimant's on-the-job training (OJT), the physicians recommended that claimant be provided with support, structure, and a "job coach." The Vocational Consultant testified at hearing that these services were indicated in the OJT plan. However, these services were not provided and a job coach had not yet been hired when claimant began the OJT program.

At hearing, claimant recognized the face of the vocational consultant who had worked with his vocational counselor for over a year, but could not remember her name. When cross-examined concerning his lack of job search, claimant did not remember the employment leads he had attempted to pursue with the assistance of his vocational counselor.

As a result of his compensable injury, claimant is unable to regularly perform gainful and suitable employment. But for the compensable injury, claimant would be willing to seek regular gainful employment. Claimant has made reasonable efforts to seek work.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant is willing to seek work and has made reasonable efforts to find employment, but has been unable to do so because of his severe physical limitations and mental deficits. He concluded, therefore, that claimant has established that he is permanently and totally disabled.

We adopt the Referee's conclusion and opinion, with the following supplementation.

Claimant sustained multiple physical injuries, a basilar skull fracture, concussion, and intercranial hemorrhages in a logging accident. There is no dispute, however, that claimant retains some physical capacity to perform work. Therefore, the question is whether claimant has established permanent and total disability status by a combination of medical and nonmedical disabilities which

effectively forecloses him from obtaining gainful employment. Welch v. Banister Pipeline, 70 Or App 699 (1984). Claimant also must demonstrate that he is willing to seek regular gainful employment and that he has made reasonable efforts to do so, unless such efforts would be futile. SAIF v. Stephen, 308 Or 41 (1989).

On review, SAIF renews its contention that claimant is not entitled to an award of permanent total disability because he is not motivated to return to work. SAIF relies primarily on the fact that claimant did not remain in an OJT program.

It is true that claimant did not complete a vocational training program. However, we find no volitional or motivational component. Rather, we conclude that claimant's failure to complete the OJT program is due to his injury-related psychological condition, rather than to a lack of motivation as SAIF suggests. See Elsie B. Greenough, 43 Van Natta 1859 (1991).

Here, neuropsychological and neuropsychiatric testing document that claimant has organic brain damage (OBS) with decreased memory, decreased concentration, decreased ability to learn new information, difficulties in organization, depression, and anxiety. Although memory aides have been provided claimant, he does not consistently remember to look to his notes to remind him of scheduled medical appointments, vocational commitments, or even purely social events.

The parties agree that "inconsistency" is typical of brain damaged individuals. To help deal with this situation, the psychologists recommended that claimant be provided with structure, support, and a job coach if retraining and return to work were to be successful. At hearing, SAIF's vocational consultant testified that the vocational counselor's plan included these services. Yet, when claimant began the OJT, no job coach had been hired, and the vocational plan indicated that claimant would be monitored once every 30 days. Missed appointments, absenteeism, and inappropriate responses to life stressors are characteristic of brain damage.

Moreover, although claimant was receiving vocational services, he continued to search the newspaper for job leads. He requested assistance from his vocational counselor to follow up on job leads at a fishery and a fruit processing plant.

From the aforementioned evidence, as well as our review of the record as a whole, we agree with the Referee's determination that claimant is unable to hold any regular job in a competitive job market, even on a part-time basis. Claimant has proven that he is permanently and totally disabled.

Because the SAIF Corporation sought reduction of claimant's permanent total disability award as granted by the Referee, and we have affirmed the Referee's order, claimant would be entitled to a reasonable attorney fee pursuant to ORS 656.382(2). However, inasmuch as claimant did not submit a brief on review, no attorney fee is awarded. Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

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

In the Matter of the Compensation of
CLARA F. KENNEDY, Claimant
WCB Case No. 91-08571
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Moller and Brazeau.

Claimant requests review of Referee Holtan's order that: (1) upheld the insurer's partial denial of claimant's current right thumb condition; and (2) declined to award penalties and attorney fees for an allegedly unreasonable and late denial. On review, the issues are compensability and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplemented ultimate findings of fact.

Claimant's compensable thumb injury combined with her preexisting right thumb arthritis to cause a need for treatment. Claimant's compensable injury is the major contributing cause of that need for treatment.

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee found that claimant failed to establish compensability of her current right thumb condition. We disagree.

We note preliminarily that the insurer's denial was termed a denial of aggravation. However, the denial also stated that medical information at that time did not substantiate that claimant's "current condition of arthritis of the first CMC joint" was related to her compensable injury. (Ex. 18). Moreover, at hearing the parties clarified that in light of the fact that treatment is directed toward claimant's arthritic condition which preexisted the compensable injury, the claim should be analyzed under ORS 656.005(7)(a)(B) to determine whether the compensable injury was the major contributing cause of her need for treatment. (Tr. 8-9). The Referee analyzed the case under that statute. We also analyze the claim under ORS 656.005(7)(a)(B), which provides:

"If a compensable injury combines with a preexisting 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."

Two physicians have offered opinions as to the issue of causation: Dr. Warren and Dr. Nathan. Dr. Warren, claimant's treating orthopedist, opines that claimant's compensable thumb injury is the major contributing cause of her need for treatment. (Exs. 14, 19A, 22). He maintains this opinion regardless of whether claimant's preexisting right thumb arthritic condition was asymptomatic before the injury or, as reported by Dr. Nathan, was intermittently symptomatic to a lesser degree prior to the injury. (Ex. 22-17). His opinion is based in part on the fact that claimant has remained symptomatic since the compensable incident in 1989, combined with the fact that claimant has the same degree of arthritis in her left thumb, but that thumb remains asymptomatic. (Ex. 22-21).

Dr. Nathan, orthopedic hand surgeon, performed an independent medical examination of claimant on July 17, 1991. As a result of his examination of claimant, Dr. Nathan opined that claimant's compensable injury neither caused nor worsened claimant's right thumb arthritis. He concluded that claimant's compensable injury was not the major contributing cause of claimant's "present condition." (Ex. 17).

We conclude that Dr. Warren's report is both more persuasive and more responsive to the dispositive inquiry raised by the statute. The language of the statute requires us to determine whether claimant's compensable injury is the major contributing cause of the "disability or need for treatment." This is precisely the question which Dr. Warren answered in the affirmative. Dr. Nathan, on the other hand, focused on whether the compensable injury had caused or pathologically exacerbated the preexisting arthritic condition. This is neither disputed nor the relevant inquiry. Moreover, Dr. Nathan's opinion that claimant's compensable injury was not the major cause of claimant's "present condition" apparently follows from his underlying conclusions that the compensable injury neither caused nor pathologically worsened the preexisting arthritis. Therefore, we find Dr. Nathan's opinion less persuasive than that of Dr. Warren.

In sum, claimant has established that her compensable injury combined with her preexisting condition to cause a need for treatment. Further, she has established that her compensable injury is the major contributing cause of that need for treatment. Therefore, she has established compensability of her resultant condition under ORS 656.005(7)(a)(B). In reaching this conclusion, we offer no opinion as to the compensability of any specific treatment as that issue was not litigated at hearing. Accordingly, we reverse the Referee on the issue of compensability of claimant's current right thumb condition.

Penalties and Attorney Fees

Claimant contends that the insurer's July 30, 1991 denial was both unreasonable and untimely. We do not agree.

With regard to the reasonableness of the denial, we conclude that Dr. Nathan's report, wherein he concluded that claimant's injury was not the major cause of her "current condition," raised a legitimate doubt as to the compensability of the claim. With regard to timeliness of the denial, we note that Dr. Warren authored a March 26, 1991 chart note indicating his intent to request authorization for surgery. (Ex. 11). However, the record does not establish when such a request, either in the form of receipt of that chart note or some other communication, was received by the insurer. The most that can be determined is that, on May 14, 1991, the insurer received a May 8, 1991 chart note indicating that Dr. Warren was awaiting authorization for surgery. (Ex. 12). Because the insurer issued its denial on July 30, 1991, we conclude that claimant has failed to establish that the denial was untimely under ORS 656.262(6).

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is \$2,600, 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 briefs, statement of services and the hearing record), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for her unsuccessful attempt to establish entitlement to a penalty and attorney fee.

ORDER

The Referee's order dated February 27, 1992 is reversed in part and affirmed in part. That portion of the Referee's order that upheld the insurer's July 30, 1991 denial is reversed. The insurer's denial of claimant's current right thumb condition is set aside and the claim is remanded to the insurer for processing in accordance with law. The remainder of the Referee's order is affirmed. For services at hearing and on review concerning the compensability issue, claimant is awarded an assessed attorney fee of \$2,600 to be paid by the insurer.

In the Matter of the Compensation of
KENNETH W. DORTCH, Claimant
WCB Case No. 91-15786
ORDER ON REVIEW
Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant, pro se, requests review of Referee Crumme's order of dismissal. On review, the issue is the propriety of the dismissal order. We affirm.

FINDINGS OF FACT

On October 28, 1991, claimant requested a hearing from a denial of August 15, 1991. The Board received the request on November 1, 1991, and notified the parties that a hearing was scheduled for February 6, 1992.

On February 5, 1992, claimant's attorney notified the Referee that claimant was withdrawing his request for hearing. Claimant's attorney drafted a letter the next day confirming the withdrawal. On February 18, 1992, the Referee entered an order of dismissal.

On March 17, 1992, the Board received claimant's request for review. Claimant has not filed a brief.

CONCLUSIONS OF LAW AND OPINION

The record establishes that claimant, through his attorney, withdrew his request for hearing. There is no evidence to contradict this finding. Accordingly, we affirm the Referee's dismissal order. See Verita A. Ware, 44 Van Natta 464 (1992).

ORDER

The Referee's order dated February 18, 1992 is affirmed.

In the Matter of the Compensation of
JAMES K. DUGAN, Claimant
WCB Case No. 91-06214
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Barber's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a psychological 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

Claimant is a police officer seeking benefits for a psychological condition. The Referee concluded that claimant had failed to prove compensability; specifically, the Referee found that claimant had failed to prove a mental or emotional disorder which is generally recognized in the medical or

psychological community, see ORS 656.802(3)(c), and, alternatively, found that claimant's symptoms were due to a demotion and that this action was reasonable, see ORS 656.802(3)(b). We agree that claimant failed to prove compensability based on the following analysis.

Under ORS 656.802(1)(b), "occupational disease" includes any mental disorder which requires medical services or results in physical or mental disability or death. The worker must prove that employment conditions were the major contributing cause of the disease and establish its existence with medical evidence supported by objective findings. ORS 656.802(2). Additionally, the employment conditions producing the mental disorder must exist in a real and objective sense and must be conditions other than those generally inherent in every working situation; there must be a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community; and there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. ORS 656.802(3)(a)-(d).

Here, claimant sought treatment from Dr. Johnson, clinical psychologist, after he was demoted from a Beaverton police captain to sergeant. The demotion was due to a decision by the mayor and chief of police to reorganize the police department, in part, by eliminating one captain position and creating an additional sergeant position. As provided by city policy, the chief chose the person to be demoted on the basis of city-wide seniority; because claimant had less city-wide seniority than the other captains, he was demoted to sergeant.

The record contains three opinions regarding claimant's psychological condition. Dr. Turco, psychiatrist, after evaluating claimant on a separate matter in March 1990, conducted another independent medical evaluation in March 1991. Dr. Turco states that claimant had:

"no specific psychological or psychiatric diagnosis. He has experienced some symptoms and complaints specifically related to the demotion. Much of this has been humiliation and anger which has resulted in some psychological complaints. His job duties have not been a problem but rather the demotion has resulted in his emotional state and his desire to leave work. The major cause of his departure from work and the consultations with the psychologist is directly related to the demotion."

(Ex. 10-4) (Emphasis in original). However, Dr. Turco did find that claimant was "chronically maladjusted and likely has a personality disorder" and that the "[m]ost likely diagnosis is that of a chronic personality disorder with passive-aggressive and passive-dependent features." (Id. at 5-6) (Emphasis in original).

Dr. Johnson disagreed with Dr. Turco's report, stating that he had diagnosed claimant with panic disorder. (Ex. 11-1). Dr. Johnson also disagreed that claimant was chronically maladjusted, stating that a 1990 MMPI, as compared to a recent MMPI, both of which were given by Dr. Turco to claimant, indicated that claimant's symptoms were due to "contextual factors surrounding [claimant's] case" and "make sense for someone who has recently experienced a major loss and for whom the future is uncertain." (Id. at 2).

In response, Dr. Turco reported that he had considered, and rejected, the diagnosis of panic disorder, noting that "it is not unusual for individuals throughout life to experience episodes of acute anxiety or even what might be termed by a novice as 'panic.'" (Ex. 13-1). Furthermore, Dr. Turco found that Dr. Johnson's notes taken when claimant sought treatment in 1989 supported his opinion that claimant was chronically maladjusted. (Id. at 2).

Claimant underwent a second independent medical examination with Dr. Goranson, psychiatrist. Dr. Goranson also disagreed with the diagnosis of panic disorder, finding that a:

"better diagnosis would be adjustment disorder with mixed emotional features which is now in remission. With respect to Dr. Turco's statement that there is no psychiatric disorder, I am taking him to mean that there is no Axis I psychiatric disorder. In fact, [claimant] does have an Axis II psychiatric disorder, a Personality Disorder. Dr. Turco feels he is passive-aggressive and passive-dependent with compulsive features. I

would add that [claimant] also has paranoid, histrionic and narcissistic features as well. I would agree with Dr. Turco that there is no current Axis I psychiatric diagnosis."

"Furthermore, I would agree with Dr. Turco that [claimant's] Axis I psychiatric diagnosis resulted from the demotion and not from the work itself."

(Ex. 14-7). Dr. Goranson also agreed with Dr. Turco that claimant's personality disorder was "well established before the time he began working for the police department." (Id. at 9).

We first find that Dr. Johnson's diagnosis of panic disorder is not persuasive. He provides very little explanation to support his opinion. On the other hand, Dr. Goranson provides a well-reasoned explanation for his opinion that claimant does not suffer from such a condition. Therefore, we find that the record does not prove a diagnosis of panic disorder. See Somers v. SAIF, 77 Or App 259 (1986).

However, we do find that Dr. Goranson's diagnosis of adjustment disorder is more persuasive than Dr. Turco's opinion that claimant suffers from no mental or emotional disorder. Again, Dr. Goranson provides a well-reasoned explanation to support his opinion that is based on the entire record. Dr. Turco's opinion is somewhat contradictory in that he states that claimant does not suffer from a psychological condition but has psychological symptoms. Therefore, we find that there is proof of a diagnosis of a mental or emotional disorder. See ORS 656.802(3)(c).

Claimant next alleges that numerous job conditions have contributed to his mental condition, including the receipt by the police department of "poison pen letters" and claimant's subsequent change from day to evening shift; disciplinary action as the result of an internal investigation for sexual harassment; statements by the police chief that appeared in the local newspaper; and his current assignment to random shifts. We conclude that the record supports none of these contentions. Both Drs. Turco and Goranson explicitly state that claimant's psychological symptoms are due to the demotion only. Although Dr. Johnson provides no explicit opinion regarding causation, we find that his report, by stating that claimant's symptoms were due to "contextual factors" and that they were typical of someone who experienced a "devastating loss," also points only to the demotion as causing claimant's condition. Therefore, we conclude that, on this record, the demotion alone affected claimant's psychological condition.

With regard to claimant's demotion, we agree with and adopt that portion of the Referee's order which concluded that the employer's conduct was reasonable. Therefore, claimant's claim fails under ORS 656.802(3)(b).

ORDER

The Referee's order dated January 9, 1992 is affirmed.

October 27, 1992

Cite as 44 Van Natta 2165 (1992)

In the Matter of the Compensation of
ROBERTO MERLOS, Claimant
WCB Case Nos. 91-11492 & 91-11092
ORDER ON RECONSIDERATION
Max Rae, Claimant Attorney
Janelle Irving (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our September 28, 1992 order which affirmed and adopted a Referee's order that set aside SAIF's denial of claimant's low back injury claim. Contending that its insured actually filed the appellant's brief, SAIF asks that our order be modified to direct its insured, rather than SAIF, to pay claimant's attorney fee award for services on Board review under ORS 656.382(2).

Included with SAIF's reconsideration motion is a copy of an April 1992 letter from SAIF to the Board in which SAIF states "SAIF will not be prosecuting the appeal of employer." Notwithstanding SAIF's announcement, the fact remains that jurisdiction vested with the Board pursuant to SAIF's

request for review of the Referee's order. Although the request stated that SAIF and its insured were requesting review, the request itself was signed and filed by SAIF's counsel.

Inasmuch as SAIF initiated review and we found that claimant's compensation should not be disallowed or reduced, we conclude that SAIF is obligated to pay to claimant's attorney the fee awarded under ORS 656.382(2). Based on SAIF's submission, it would appear that SAIF and its insured may have had an understanding concerning who would bear ultimate responsibility for the costs of the appeal. Should that assumption be accurate, resolution of that dispute rests with SAIF and its insured, not this forum. In conclusion our duty is to award an attorney fee for services on review to be paid by the entity that initiated the appeal. Since that entity is SAIF, we decline to modify our prior order.

Accordingly, as supplemented herein, we adhere to our September 28, 1992 order in its entirety. The parties' rights of appeal shall continue to run unabated from the date of our September 28, 1992 order.

IT IS SO ORDERED.

October 27, 1992

Cite as 44 Van Natta 2166 (1992)

In the Matter of the Compensation of
EDWARD H. PORRITT, Claimant
 WCB Case Nos. 91-14975 & 91-09619
 ORDER ON REVIEW
 Hollis Ransom, Claimant Attorney
 Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee Menashe's order that upheld the self-insured employer's September 26, 1991 denial of claimant's carpal tunnel condition. Claimant also moves for remand to admit additional evidence regarding an untimely request for hearing from an April 19, 1991 denial. On review, the issues are remand and compensability. We deny the motion for remand and affirm the Referee's order.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Remand

The Referee considered two denials of claimant's carpal tunnel condition. Regarding an April 19, 1991 denial, the Referee found that claimant filed a request for hearing more than 60 days after notification of the denial. The Referee further found that there was no evidence of "good cause" for failure to file the request by the 60th day and so upheld the denial.

Under ORS 656.319, "a hearing * * * shall not be granted and the claim shall not be enforceable unless" a "request for hearing is filed not later than the 60th day after the claimant was notified of the denial" or "the request is filed not later than the 180th day after notification of denial and the claimant establishes at a hearing that there was good cause for failure to file the request by the 60th day after notification of denial." Claimant does not disagree with the Referee's conclusion that he did not comply with ORS 656.319 with respect to the filing of his request for hearing from the April 19, 1991 denial. Instead, claimant moves for remand on the basis that the record was improperly, incompletely or otherwise insufficiently developed because his attorney "inadvertently failed to solicit * * * testimony from Claimant while on the stand" that he relied on statements from an independent medical examiner that he "would take care" of the denial.

Under ORS 656.295(5), the Board may remand a 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).

We find that claimant has failed to satisfy the requirements for remand. The evidence sought to be admitted was obtainable at hearing. Further, we find that the additional evidence is not reasonably likely to affect the outcome of the case. Therefore, we deny claimant's request for remand.

Compensability

The Referee found that the September 26, 1991 denial was in response to a claim dated March 31, 1991 alleging an injury of October 11, 1990. Because "there was no injury on or about" that date, he upheld the denial. The Referee further found that, even if construed as referring to the September 14, 1990 injury, "the evidence does not support compensability."

Claimant asserts that the 801 form mistakenly listed an injury date of October 11, 1990 but that the claim was based on the September 14, 1990 incident. Claimant further contends that he proved this work incident was a material contributing cause of his carpal tunnel condition and, therefore, he has established compensability. See ORS 656.005(7)(a).

On September 14, 1990, claimant fell while working on a bridge project. The employer eventually accepted a right-side thoracic strain in connection with the work incident. We agree with claimant that his carpal tunnel condition was litigated as an injury caused by the September 14, 1990 incident. Although the 801 form listed a date of October 11, 1990, claimant's attorney clarified at hearing that the condition was caused by the September 1990 fall. (Tr. 16).

The record contains several opinions regarding causation. Dr. Durkan, orthopedist, reported that claimant "may indeed have developed low grade carpal tunnel syndrome from his accident[.]" (Ex. 3-6). Dr. Durkan referred claimant to Dr. Moser, neurologist. Dr. Moser stated that, "[b]ecause [claimant] has bilateral carpal tunnel syndrome which may or may not be related to his injury[,] I dispensed bilateral wrist splints to him." (Ex. 5-3).

Dr. Seres, director of the Northwest Pain Center, concluded that he did not feel that "claimant's carpal tunnel problem is related to the September 14, 1990 on-the-job injury. His carpal tunnel problem has developed subsequent to that injury." (Ex. 8-7). Dr. Seres based his opinion on a closing examination that he had performed in January 1991, during which claimant had no complaints concerning his hands, and his opinion that, based on the mechanism of the injury, claimant would have experienced significant distress upon injury if his carpal tunnel condition had developed at that time. (Id. at 7-8). Dr. Seres found that claimant's "recent activities are more likely the cause of his carpal tunnel distress." (Id. at 8).

Dr. Button, surgeon, conducted an independent medical examination. His initial report stated that the September 1990 fall was the "major factor relative to the development of his carpal tunnel syndromes." (Ex. 12-5). This opinion was based only on an EMG report and claimant's own history. (Ex. 12A-2). After Dr. Button reviewed the medical file, he reported that "[n]ow with the benefit of the medical records I would change my initial impression about causation of his carpal tunnel syndromes and do not believe they are directly related to the injury[.] * * * It would appear much more likely to me that the progression of his carpal tunnel syndrome relate to his occupational exposure more recently, specifically since his claim was closed." (Ex. 12-2).

We conclude that claimant failed to prove that the September 1990 injury was a material cause of his carpal tunnel condition. Drs. Durkan and Moser indicated only a possibility that the accident was a cause of claimant's condition, which is not sufficient to prove a causal relationship. See Gormley v. SAIF, 52 Or App 1055, 1060 (1981). Dr. Seres reports that claimant's accident did not cause his carpal tunnel condition. Although Dr. Button initially supported compensability, we find his subsequent opinion to be more persuasive since it was based on a review of the medical records. Therefore, we also conclude that claimant failed to establish compensability of his carpal tunnel condition.

ORDER

The Referee's order dated February 13, 1992 is affirmed.

October 28, 1992

Cite as 44 Van Natta 2168 (1992)

In the Matter of the Compensation of
RANDY S. BARTLETT, Claimant
WCB Case No. 91-12835
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Kinsley and Brazeau.

The insurer requests review of Referee Crumme's order which: (1) awarded claimant 49 percent (73.50 degrees) scheduled permanent partial disability for the loss of use or function of his right forearm, whereas the Determination Order awarded no scheduled disability; and (2) directed it 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 modify in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for his "Ultimate Findings of Fact" as they relate to the validity of the Director's temporary rule.

CONCLUSIONS OF LAW AND OPINIONDirector's Temporary Rules

At hearing, the primary issue was which disability standards applied in determining claimant's impairment. The standards in effect at the time of claimant's March 18, 1991 Determination Order were the Director's temporary standards, adopted effective October 1, 1990. However, claimant argued that those standards are invalid because the Director's findings, citation of statutory authority, and statement of need were inadequate. The Referee agreed and, therefore, declined to apply the temporary standards in determining claimant's scheduled disability award. Instead, he applied the permanent rules that became effective January 1, 1989.

Subsequent to the Referee's order, we declined to invalidate the Director's temporary rules. Eileen N. Ferguson, 44 Van Natta 1811 (1992). Consequently, we apply them herein in determining claimant's scheduled permanent disability award. See also Edmunson v. Dept of Insurance and Finance, 314 Or 291 (1992).

Impairment

As to claimant's forearm impairment, the Referee concluded, based on the un rebutted ratings of claimant's attending physician (See Ex. 17-5), that, under former OAR 436-35-110(3)(a), claimant was entitled to a combined value of 44 percent for sensory loss and loss of strength in his right forearm. We agree and adopt the Referee's conclusions and reasoning in that regard.

As to claimant's chronic condition, the Referee determined pursuant to former OAR 436-35-010(7) and former OAR 436-35-070(4), (5) and (6) that claimant was entitled to 5 percent impairment ratings for chronic conditions limiting repetitive use of his right thumb, index finger, middle finger and hand. After converting the 5 percent chronic condition rating for each finger to a hand value, the Referee added those values for a total of 4 percent impairment of the right hand. The Referee then combined that value with the 5 percent chronic condition rating for the right hand, giving claimant a total right hand impairment of 9 percent.

However, under the temporary standards, where "impairment in a body part is equal to or in excess of 5 percent, the worker is not entitled to any scheduled chronic condition impairment." Former OAR 436-35-010(8)(a)(temp.). Here, claimant received an impairment rating of 44 percent for his right forearm. For the purpose of considering an award for chronic condition impairment, claimant's right forearm is the part of the same body part as his right thumb, index finger, middle finger and hand. See former OAR 436-35-010(8) (temp.). Consequently, claimant is not entitled to an additional impairment rating for chronic conditions limiting repetitive use of his right thumb, index finger, middle finger and hand. Therefore, we conclude that claimant's total impairment rating for loss of use or function of his right forearm is 44 percent.

Rate Per Degree

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), where 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 15, 1992 is modified in part and reversed in part. That portion of the order awarding claimant 49 percent (73.50 degrees) is modified to award 44 percent (66 degrees) scheduled permanent disability for the loss of use or function of the right forearm. Claimant's attorney fee is adjusted accordingly. That portion of the order which directed the insurer to pay claimant's scheduled permanent disability award at the rate of \$305 per degree is reversed.

October 28, 1992

Cite as 44 Van Natta 2169 (1992)

In the Matter of the Compensation of
KEITH D. COOPER, Claimant
WCB Case No. 91-09376
ORDER ON REVIEW
Charles Robinowitz, Claimant Attorney
Douglas Oliver (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of that portion of Referee Thye's order that: (1) increased claimant's unscheduled permanent disability award for a right shoulder injury from 6 percent (19.2 degrees), as awarded by an Order on Reconsideration, to 8 percent (25.6 degrees) unscheduled permanent disability; and awarded no scheduled permanent disability in addition to the 28 percent (13.44 degrees) awarded by an Order on Reconsideration for loss of use or function of the right thumb. Claimant also contends that he should receive an award for sensory loss and loss of strength for his right forearm. On review, the issue is extent of scheduled and 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 OPINIONUnscheduled Permanent Disability

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

Scheduled Permanent Disability

We begin with a correction: The right, not the left, thumb and arm are the subject of this claim.

Right Forearm

We affirm and adopt the Referee's conclusions and opinion with the following correction. See former OAR 436-35-110(3)(a) rather than 436-35-310(3)(a) (emphasis added).

Right Thumb

The language of the Opinion and Order on this issue is somewhat confusing. We reconstruct the issue and outcome as follows. The Order on Reconsideration rated claimant with 13 percent for sensory loss of the right thumb, which was combined with 17 percent for loss of range of motion for an award of 28 percent for the loss of use or function of the right thumb. At hearing, claimant contended that sensory loss for the ulnar side of the thumb should have been rated at 17 percent for a complete loss of sensation rather than 13 percent for the loss of protective sensation only. The Referee made no additional award for the sensory loss. Claimant raises the same issue on review.

Scheduled impairment values in this case are determined by application of former OAR 436-35-010 through 436-35-260, as amended by temporary rule (see WCB Admin Order 15-1990).

Dr. Breen, claimant's treating physician, stated that claimant has anesthesia on the ulnar side of the thumb distal to the DIP joint. (Ex. 16). Dr. Corrigan, who examined claimant as a medical arbiter, stated that claimant has minimal if any sense of touch or sensation on the ulnar half of the pad of the right thumb distal to the scar at the DIP joint. He noted that claimant was barely able to appreciate pin prick and that two point discrimination is 1.4 cm. (Ex. 23-4). Accordingly, based on the findings of the arbiter, we conclude that claimant has a complete loss of sensation on the ulnar portion of the right thumb. Consequently, we rate the loss of sensation as 17 percent of the thumb.

We combine the 17 percent rating for loss of range of motion in the thumb with the 17 percent rating for loss of sensation for a total rating of 31 percent loss of use or function of the right thumb. See former OAR 436-35-075(5).

ORDER

The Referee's order dated November 29, 1991 is affirmed in part and modified in part. In addition to claimant's prior award of 28 percent (13.44 degrees) scheduled permanent disability award for his right thumb, claimant is awarded 3 percent (1.44 degrees), for a total award to date of 31 percent (14.88 degrees) for loss of use or function of the right thumb. The remainder of the order is affirmed. 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
CURLEE FISHER, Claimant
WCB Case No. 91-17213
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Tooze, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Kinsley.

The insurer requests review of Referee Podnar's order which directed it to pay claimant's scheduled permanent disability award at the rate of \$305 per degree. In his brief, claimant argues that he is entitled to additional impairment ratings for his right index, ring, and little fingers. On review, the issues are extent of scheduled permanent disability and rate of payment for scheduled permanent disability benefits. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for the last finding.

CONCLUSIONS OF LAW AND OPINION

Extent of Scheduled Disability

The Referee concluded that there was insufficient medical evidence that the loss of range of motion in claimant's right index, ring, and little fingers were causally related to his compensable injury. Although we find that claimant has documented a decreased range of motion in these three digits (Exs. 17-1, 34-3), we agree with the Referee that there is no medical evidence that specifically relates this impairment to claimant's January 28, 1990 injury.

Claimant argues on review that his attending physician, Dr. Layman, would not have made these range motion findings unless the impairment was related to his compensable injury. We find this argument speculative. Claimant also points to his 801 Form, which indicates that his right "hand" was the body part affected by the injury, as proof that the decreased range of motion in these fingers are compensably related. (Ex. 7). However, the 801 form merely identifies the body part injured. It is not medical evidence that claimant's impairment in his fingers is causally related to his compensable injury.

Consequently, we conclude that claimant has failed to establish entitlement to an impairment rating for loss of range of motion in his right index, ring, and little fingers. Therefore, finding no other basis for increasing claimant's scheduled permanent disability award, we affirm and adopt that portion of the Referee's order.

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).

ORDER

The Referee's order dated February 27, 1992 is reversed in part and affirmed in part. Those portions of the Referee's order which directed the insurer to pay claimant's scheduled permanent

disability award at the rate of \$305 per degree and pay an out-of-compensation attorney fee are reversed. The remainder of the order is affirmed.

October 28, 1992

Cite as 44 Van Natta 2172 (1992)

In the Matter of the Compensation of
LUCKY L. GAY, Claimant
WCB Case No. 90-22410
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Paul L. Roess, Defense Attorney

Reviewed by the Board en banc.¹

Claimant requests review of those portions of Referee Kinsley's order that upheld the insurer's denial of his injury claims for carpal tunnel syndrome (CTS) and thoracic outlet syndrome (TOS). The insurer cross-requests review of that portion of the order that set aside its denial of claimant's aggravation claim for a cervical strain and disc herniation at C6-7. On review, the issues are compensability and aggravation. We reverse.

FINDINGS OF FACT

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

By October 1988, claimant had complaints of increased neurological-type symptoms in his right arm. (Ex. 8). By December 1988, claimant had complaints of numbness in his arms and hands. (Ex. 12A-2). During 1989, claimant had complaints of arm numbness and hand pain and numbness. (Exs. 12B-2, 14-2, 19-1, 27-1). Dr. LaFrance, treating neurologist, noted that when he first began treating claimant in January 1990 he had complaints of pain radiating into his hands with numbness in both hands. (Ex. 61A).

Dr. Dodds, orthopedist, treated claimant on three occasions: November 5, 1990, December 5, 1990 and December 13, 1990. (Ex. 87).

Claimant's exterminator activities while self-employed were the major contributing cause of his worsened condition in 1990.

CONCLUSIONS OF LAW AND OPINION

Compensability of CTS and TOS

Citing ORS 656.005(7)(a)(A), the Referee determined that claimant had not met his burden of proving that the work injury was the major contributing cause of the bilateral CTS and TOS conditions.

ORS 656.005(7)(a)(A) provides, in relevant part, that "[n]o injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition." Subsequent to the Referee's order, we held in Julie K. Gasperino, 43 Van Natta 1151 (1991), that the phrase "consequential condition" in ORS 656.005(7)(a)(A) applies only to conditions that subsequently arise from compensable injuries sustained in the industrial accident, as opposed to conditions that are caused by the accident itself. Accordingly, we held that the 1990 amendments to the definition of a compensable injury did not affect the standard of compensability for conditions directly related to the underlying compensable event.

¹ Board Member Kinsley was the Referee on this case. Consequently, she has not participated in this review. OAR 438-11-023.

The Court of Appeals has recently affirmed our decision, explaining that

"[t]he 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." Albany General Hospital v. Gasperino, 113 Or App 411, 415 (1992)

In this case, we conclude that claimant's CTS and TOS conditions are not properly classified as a "consequential condition" subject to the major contributing cause test of ORS 656.005(7)(a)(A). Claimant seeks compensation for conditions that he alleges were directly caused by the June 1988 industrial accident, rather than conditions that arose as a "consequence" of the compensable thoracic and lumbar injuries that he sustained in that accident. The record supports his contention. Therefore, in order to establish compensability, claimant must show that the June 1988 accident was a material contributing cause of his CTS and TOS conditions and need for medical services.

Bilateral CTS Condition

On July 25, 1990, Dr. LaFrance, treating neurologist, performed nerve conduction studies which he found "diagnostic of carpal tunnel syndrome." (Ex. 60).

On September 21, 1990, Dr. Carter, hand surgeon, examined claimant. He did not discuss the possibility of CTS other than to note that there was no particular clinical evidence of CTS. (Ex. 62-2). However, Dr. Carter did not have Dr. LaFrance's nerve conduction tests which showed evidence of bilateral CTS. Furthermore, Dr. Carter found evidence of bilateral upper extremity nerve compression and recommended further tests to determine the location of the nerve compression. (Ex. 62-2). Given the fact that Dr. Carter did not have the nerve conduction tests and presented no discussion of the CTS, we do not find his report persuasive regarding the CTS issue.

On October 30, 1990, Dr. Sloop, examining surgeon, examined claimant and agreed with Dr. Carter that clinical CTS findings were lacking. (Exs. 64, 65). However, at the time of this opinion, Dr. Sloop did not have Dr. LaFrance's nerve conduction studies. After being provided these studies, Dr. Sloop noted, without comment, that these studies were interpreted as "diagnostic of carpal tunnel syndrome." (Ex. 77). He did not dispute this interpretation. Furthermore, Dr. Sloop opined that the history indicates that claimant's upper extremity symptoms are related to the June 1988 accident. (Ex. 64-1).

Dr. Dodds, orthopedist, treated claimant on three occasions and noted that clinical findings and nerve conduction tests were consistent with the presence of bilateral CTS. (Exs. 66, 71, 76). However, Dr. Dodds thought that a more proximal etiology should be sought. As to causation, Dr. Dodd opined that, although he was unable to directly relate the CTS pathology to the June 1988 work accident, it was possible that this pathology was produced "in a secondary fashion from the presence of more proximal pathology" which was in major part caused by the work accident. (Ex. 87-1).

Dr. LaFrance, treating neurologist, repeated the nerve conduction tests on December 19, 1990 and opined that claimant had bilateral CTS which required surgery. (Exs. 71, 78). He opined that the major contributing cause of the bilateral CTS was the June 1988 work accident because the impact resulted in significant trauma to the hands and wrists which initiated a progressive scarring. (Ex. 86).

The Referee did not find Dr. LaFrance's opinion persuasive because LaFrance apparently thought that claimant had gripped the steering wheel with both hands while bracing himself as the truck rolled onto its side. However, from claimant's testimony and his report to Dr. Carter, it appears most likely that claimant gripped the bucket seat next to him with one hand and the steering wheel with the other. (Ex. 62-1, Tr. 9). We do not find that this difference diminishes the persuasiveness of Dr. LaFrance's opinion. It was the significant trauma of the gripping and bracing action and the subsequent impact that initiated the progressive scarring, not the specific objects that he gripped.

On this basis, we find that claimant has established that the June 1988 work accident was a material contributing cause of his bilateral CTS. Furthermore, we note that Dr. LaFrance's opinion is

supported in part by the opinions of Drs. Sloop and Dodds, both of whom opine that the upper extremity symptoms are related to the June 1988 accident.

Bilateral TOS Condition

Dr. Carter noted that claimant had evidence of bilateral upper extremity nerve compression which was probably the result of bilateral TOS. (Ex. 62-2). However, he stated that further tests were needed to better locate the nerve compression. These tests were not performed. As to causation, he noted the possibility that a nerve compression injury at a superior level could be related to the work injury. However, a "possibility" is not sufficient to meet claimant's burden of proof. Gormley v. SAIF, 52 Or App 1055 (1981).

On November 5, 1990, as a result of claimant's complaints and physical findings, Dr. Dodds opined that his most significant problem was likely due to TOS. (Ex. 66-2). However, Dr. Dodds did not explicitly address the cause of this likely TOS, although he stated that there was a "high likelihood of probability" that the June 1988 accident was the major contributing cause of claimant's "proximal contribution to his symptom complex." (Ex. 87-1).

Although Dr. Sloop found bilateral thoracic outlet compression present with respect to the arteries, he doubted that claimant had thoracic outlet syndrome "with respect to the potential neurologic consequences of thoracic outlet compression." (Ex. 64-1). Dr. Sloop requested further tests to allow better assessment of the thoracic outlet compression. These tests were not performed. As to causation, Dr. Sloop opined, without explanation, that the June 1988 work injury did not cause the thoracic outlet arterial compression. (Ex. 64-1). However, he also noted that the history indicated "that the present neck and shoulder girdle and upper extremity symptoms are, indeed, related to the June, 1988 accident, but not via the route of thoracic outlet compression syndrome." (Ex. 64-1).

Dr. LaFrance found that claimant had clinical complaints consistent with TOS. (Ex. 86-2). He opined that the mechanism of the June 1988 accident would have caused stress to be transmitted through the arms and shoulders, most likely causing damage to the soft tissues in that area which appeared to be the basis of the TOS. (Ex. 86).

The Board generally gives greater weight to the conclusions of a treating physician; however, it will not so defer when there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983); Nancy E. Cudaback, 37 Van Natta 1580, withdrawn on other grounds, 37 Van Natta 1596 (1985), republished 38 Van Natta 423 (1986).

The Referee found Dr. LaFrance's opinion unpersuasive because he apparently understood that claimant was gripping the steering wheel with both hands rather than gripping the bucket seat with one hand and the steering wheel with the other. However, as noted above, we do not find that this difference diminishes the persuasiveness of Dr. LaFrance's opinion. The Referee also found Dr. Sloop's opinion more persuasive based on his expertise in thoracic surgery. However, given Dr. LaFrance's expertise as a neurologist, we find that he is as qualified as Dr. Sloop to give an opinion regarding the existence and cause of TOS. Therefore, we find no persuasive reasons not to defer to Dr. LaFrance.

In addition, a claimant need not prove a specific diagnosis if he proves that his symptoms are attributable to his work. Boeing Aircraft Company v. Roy, 112 Or App 10 (1992); Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988). Here, although Dr. Sloop disputes the diagnosis of TOS, his opinion that the upper extremity symptoms are related to the 1988 work injury supports Dr. LaFrance's opinion. Accordingly, on this record, we find that claimant has established that the work injury is a material contributing cause of the TOS.

Aggravation

The Referee concluded that claimant had established compensability of his worsened cervical condition under ORS 656.273. In this regard, a compensable worsening is generally established by proof that the compensable injury is a material contributing cause of the worsened condition. Robert E. Leatherman, 43 Van Natta 1677 (1991). Before the 1990 amendments to ORS 656.273, a worsening was compensable even if the major contributing cause of the worsened condition was nonindustrial so long

as the compensable injury remained a material contributing cause of that condition. See Coddington v. SAIF, 68 Or App 439 (1984); Grable v. Weyerhaeuser Company, 291 Or 387 (1981). In Grable, the Court held that if a compensable injury is a "material contributing cause" of the worsened condition, it thereby follows that the worsened condition is not the result of an "independent, intervening" nonindustrial cause. 291 Or at 400-01.

As amended in 1990, however, ORS 656.273(1) provides that "if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable." Therefore, as a result of the 1990 amendment, the rule enunciated in Grable no longer necessarily follows, *i.e.*, under the 1990 amendments, a worsening may not be compensable even though the accepted injury is a material contributing cause of that worsened condition if the major cause of the worsening is an off-work "injury".

Here, there is no evidence that claimant sustained a discrete injurious incident while off work. Based on the absence of "a specific subsequent injury," the Referee concluded that the 1990 amendments did not apply and that claimant was required only to establish a material causal relationship between his worsened condition and the accepted injury. However, the insurer contends that any worsening of claimant's cervical condition was caused, in major part, by claimant's subsequent self-employment activities as an exterminator. Although no single injurious incident occurred during these activities, the insurer contends that claimant cannot prevail if the record establishes that these activities were the major contributing cause of his worsened condition. Accordingly, we must decide whether the 1990 amendment applies only to worsenings involving injurious nonindustrial incidents or also to worsenings involving injurious activities.

The dispositive inquiry involves the scope of the term "injury" as it appears in the relevant portion of the statute. The word "injury" is not separately defined in the Workers' Compensation Law. See Brown v. SAIF, 79 Or App 205, 208 ft nt 1 (1986). Instead, the statute provides a definition for a "compensable injury." ORS 656.005(7)(a) defines a "compensable injury" as "an accidental injury * * * arising out of and in the course of employment * * *." (Emphasis supplied). Claimant contends that we should interpret the word "injury" in a manner that would distinguish it from an occupational disease. In effect, claimant would have us insert the word "accidental" into the statute as a modifier of the word "injury." In this regard, for purposes of distinguishing an "accidental injury" from an "occupational disease," whether an "injury" has occurred during a short, discrete period of time is a crucial inquiry.² James v. SAIF, 290 Or 343 (1980); Donald Drake Co. v. Lundmark, 63 Or App 261 (1983), rev den 296 Or 350 (1984).

However, we are not persuaded that it is appropriate to incorporate into ORS 656.273 the distinction defined by case law between "accidental injuries" and "occupational diseases." To the contrary, the word "injury" appears at numerous places in ORS 656.273 in a sense that includes both accidental injuries and occupational diseases. The first sentence of ORS 656.273(1) provides: "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury." (Emphasis supplied). The reference to an "injured worker" and the "original injury" has never been interpreted to limit application of the statute only to workers who have suffered an injury as the result of a discrete incident. Rather, the statute has been uniformly applied both to "injuries" that were sudden in onset (accidental injuries) as well as "injuries" that arose more gradually from an extended period of exposure to injurious activities or conditions (occupational diseases). Accordingly, to the extent guidance can be gained from use of the word "injury" throughout ORS 656.273, such use supports a broad interpretation of the term rather than a restrictive interpretation.

We further note that case law prior to the 1990 amendments to ORS 656.273 made no distinction between intervening nonindustrial incidents and intervening noncovered activities. See Barrett v. Union

² The significance of the distinction between an industrial injury and an occupational disease was limited by the enactment of ORS 656.005(7)(a) which imposes the major contributing cause burden of proof for "consequential conditions" of compensable injuries (ORS 656.005(7)(a)(A)) and for "resultant conditions" from a combination of a compensable injury and a preexisting condition (ORS 656.005(7)(a)(B)). As a result of these amendments, industrial injuries are analyzed in many respects similarly to occupational diseases.

Oil Distributors, 60 Or App 483, 487 (1982)(to establish a compensable aggravation claimant must prove a worsened condition, a direct and compensable correlation to the previous compensable injury, and the absence of any intervening injuries or contributive exposures). In this regard, the facts of Peterson v. Eugene F. Burrill Lumber, 57 Or App 476 (1982), aff'd on other grounds 294 Or 537 (1983), are very similar to the case before us. In Peterson, the claimant sustained an on-the-job back injury. His back condition deteriorated in later years during which the worker was self-employed in an occupation involving bending and lifting. The claimant was not covered by workers' compensation insurance during his self-employment. The Court of Appeals determined that to establish a compensable aggravation claim, the applicable test was the "material contributing cause" test found in Grable, supra. See also Dick A. Comstock, 36 Van Natta 1115 (1984), aff'd Int'l Paper v. Comstock, 73 Or App 342 (1985). Therefore, to adopt the interpretation urged by claimant, we would be required to conclude that the Legislature intended to change the result of the Grable decision but not the result of subsequent cases which have applied the Grable analysis to claims involving off-work activities. We do not find support for such a distinction.

Legislative history surrounding enactment of this amendment to ORS 656.273 is limited. See Statements of Representative Edmunson, May 3, 1990 Joint Interim Special Committee Meeting, tape 2, side B; and Representative Mannix, May 7, 1990 House Special Session Meeting, tape 2, side A. Both Representative Edmunson's and Mannix's comments referred to facts similar to those in Grable v. Weyerhaeuser Company, supra, which involved an injurious off-work incident that the claimant sustained on the roof of his residence. However, the fact that the legislative history refers to a hypothetical involving an injurious incident does not persuade us that the legislative intent was to treat injurious activities differently where the record establishes that the injurious activities are the major contributing cause of a worsened condition.

In the absence of any direct legislative history on the subject, we look to the more general intent of the Legislature and which interpretation of the statute more likely effectuates that intent. See Aetna Casualty Co. v. Aschbacher, 107 Or App 494, 499-500, rev den 312 Or 150 (1991). In this regard, Representative Mannix explained the relevant amendment on the basis that "in most of these circumstances right now the workers' comp system under aggravation claims is paying benefits for things that ought not be covered by workers' compensation." Tape Recording, House Special Session, Floor Debate, May 7, 1990, Tape 2, Side A. In a similar vein, ORS 656.005(7)(a) was amended by the 1990 Special Session Legislature to incorporate the "major contributing cause" standard (which already existed in the context of occupational diseases) into certain claims involving accidental injuries. See Albany General Hospital v. Gasperino, supra. At the May 7, 1990 meeting of the Interim Special Committee on Workers' Compensation, Senator Kitzhaber explained the imposition of the major contributing cause burden of proof in the context of ORS 656.005(7)(a) as follows:

"If it is something due primarily to the work place then clearly the work place should pay for it. But if it is something that is due to something else, then clearly it is a larger social question that should fall into our larger health care system." Tape Recording, Interim Special Committee on Workers' Compensation, May 7, 1990, Tape 26, Side A at 150.

In light of these expressions of legislative purpose, we can discern no rationale for restrictively reading the term "injury" as used in ORS 656.273 to include only injurious incidents where it is proven that injurious off-work activities account, in major part, for the worsened condition.³ If we were to hold

³ As a practical matter, a medical opinion that refers to no specific, identifiable activities or exposures as the major cause of a worsened condition would likely lack persuasiveness. Stated otherwise, a medical opinion that, for example, simply referred to general activities of daily living as the major cause of a worsened condition would presumably not persuasively support a finding of noncompensability. As stated by the West Virginia Supreme Court in Wilson v. Workers' Comp. Comm'r, 328 S.E.2d 485 (W. Va. 1984):

"Thus, we believe that as a general rule, if a worker's compensation claimant shows that he received an initial injury which arose out of and in the course of his employment, then every normal consequence that flows from the injury likewise arises out of the employment. If, however, a subsequent aggravation of the initial injury arises from an independent intervening cause not attributable to the claimant's customary activity in light of his condition, then such aggravation is not compensable."

otherwise, then, for example, a worsening which resulted in major part due to a single day of reroofing activity would not be compensable whereas a worsening which resulted in major part from several weeks of reroofing activity would be compensable. Such an interpretation of the statute would create different levels of proof for different aggravation claims based solely on whether the worsening followed an injurious incident or, instead, injurious activities. Neither the legislative history nor any rationale of which we are aware supports such a distinction.

In sum, we conclude that an interpretation of the amendment to ORS 656.273 which includes both injurious incidents and activities is within the letter of the statute. However, even if such an interpretation is not within the letter of the statute, we find that the legislative history supports such an interpretation. As stated by the Oregon Supreme Court in Johnson v. Star Machinery Co., 270 Or 694 (1974) [recently quoted by the Court of Appeals in the case of Toole v. EBI Companies, 314 Or 102 (1992)]:

"[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.

Although we have concluded that an insurer may point to off-work activities as the cause of a worsened condition, here the insurer points to claimant's self-employment activities as the major contributing cause of his worsened condition. Therefore, we must decide whether this matter should be addressed under the law of responsibility. As previously noted, before the 1990 amendments, an allegation that noncovered employment activities were the cause of a worsened condition was not treated as a responsibility issue, but instead was addressed under the Grable analysis. See Int'l Paper v. Comstock, *supra*; Peterson v. Eugene F. Burrill Lumber, *supra*. We see no reason to change such analysis in light of the amendments to ORS 656.273.

Moreover, we note that new ORS 656.308(2) provides, in pertinent 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."

It is clear from the language of the statute that the purpose of notice of intent to disclaim responsibility is to put an injured worker on notice that his condition may be compensable against another employer so that he may file a claim with that employer. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 ft nt 1 (1992). Where that "other employer" is claimant himself, and claimant has no workers' compensation insurance, the notice provision of ORS 656.308(2) makes little sense. Therefore, we conclude that the insurer's defense to the claim did not require prior notice of intent to disclaim responsibility.

Accordingly, we turn to the merits of claimant's aggravation claim in light of our conclusion concerning the standard of proof.

Dr. LaFrance, neurologist, first examined claimant in January 1990. On February 24, 1991, he reported:

"I believe that most likely the [compensable injury] would very typically have caused cervical strain and injury and appears to be most likely the process that is responsible for any herniation and continued pain. But, again, I would like to state that the patient's work as an exterminator appears to have significantly exacerbated that process. Doing that work with having to use his arms overhead and often look up and twist his neck into awkward angles certainly has served to cause an increase in the pain from that region. During the course of the summer of 1990 the patient became progressively disabled from the combination of these three complaints, as well as the persistence of a chronic low back pain problem. His continued attempts to work as an

exterminator, I believe, was the process that led up to this overall deterioration in his condition." (Emphasis supplied).

The other physician who discusses claimant's cervical condition is Dr. Dodds. Dr. Dodds reported that claimant's "exterminating business would seem to be contributing to some of his present complaints." (Ex. 64). However, Dr. Dodds focused his comments on claimant's thoracic vascular outlet compression. We conclude that his opinion is not helpful in answering this issue involving claimant's cervical condition.

Accordingly, we are left with Dr. LaFrance's opinion. We conclude in this regard that his opinion in general, as well as his statement in particular that claimant's work as an exterminator "was the process that led up to the overall deterioration in his condition," supports a conclusion that those activities were the major contributing cause of claimant's worsened condition. See McClendon v. Nabisco Brands, 77 Or App 412 (1986) ("magic words" of causation not required). Therefore, we conclude that claimant has failed to establish a compensable aggravation resulting from his cervical condition.

Attorney Fees

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue concerning his CTS and TOS conditions. 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 attorney's services at hearing and on review concerning the compensability issues is \$2,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the hearing record and claimant's appellant's and cross-respondent's briefs), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated May 15, 1991 is reversed. That portion of the order that upheld the insurer's denial of the bilateral carpal tunnel syndrome and bilateral thoracic outlet syndrome conditions is reversed. The insurer's denial of those conditions is set aside and the claim is remanded to the insurer for processing in accordance with law. That portion of the Referee's order that set aside the insurer's denial of claimant's aggravation claim relating to his cervical condition is reversed. The insurer's aggravation denial is reinstated and upheld. In lieu of the Referee's attorney fee award, for services at hearing and on review concerning the compensability issues, claimant's attorney is awarded an assessed fee of \$2,500, to be paid by the insurer.

Board Member Westerland, specially concurring.

I agree with the majority's conclusion that an off work "injury" within the meaning of ORS 656.273(1) may include an injury resulting from a specific incident as well as an injury caused by activities involving micro-traumas to the body that would constitute a compensable occupational disease if the off work activities were in covered employment. The problem here is that claimant elected not to have workers' compensation insurance coverage for his self-employment. See ORS 656.039. Had he elected to have such coverage, ORS 656.308 would apply, and the question before this Board would be one of responsibility rather than compensability. Specifically, we have held that where an accepted injury is followed by an increase in disability during employment with a later carrier, under ORS 656.308(1), responsibility rests with the original carrier unless claimant sustains an actual independent compensable injury involving the same condition during the subsequent employment. If such an injury occurs, responsibility shifts to the later carrier. Ricardo Vasquez, 43 Van Natta 1678 (1991). For purposes of ORS 656.308(1), a "new compensable injury" includes a new occupational disease. Donald C. Moon, 43 Van Natta 2595 (1991).

Here, Dr. LaFrance opined that claimant's "continued attempts to work as an exterminator, I believe, was the process that led up to his overall deterioration in his condition." On the basis of that opinion, the majority correctly finds that claimant's work activities in his self-employment were the major contributing cause of his worsened condition. Thus, had claimant elected to obtain workers'

compensation insurance coverage for his self-employment, the insurer would have established, by the opinion of Dr. LaFrance, the occurrence of a new occupational disease in the later self-employment. Under ORS 656.308(1), responsibility would have shifted from the insurer to the claimant's self-employment insurance policy.

Alternatively, assuming that we were to interpret Dr. LaFrance to opine that the off-work activities were the major contributing cause of only a symptomatic (as opposed to pathological) worsening of the condition, the issue would still be responsibility rather than compensability, if claimant had elected coverage for his self-employment. Under such circumstances, a new compensable injury would not be established by Dr. LaFrance's opinion, and the insurer, as the last carrier, would remain responsible for the worsening. Ricardo Vasquez, supra.

If there is one lesson to be learned from the present case, it is that individuals engaged in self-employment activities that involve repetitive stooping, bending, reaching or other physical labor would be wise to consider the cost of obtaining workers' compensation insurance for themselves as one of the necessary costs of doing business. Furthermore, I agree with the majority that carriers should not interpret our holding in this case as an invitation to deny aggravation claims based on medical evidence that attributes a worsening to normal activities of daily living. The present case involves activities that would (or would nearly) satisfy the demanding definition of an occupational disease, and the resulting disability would be compensable if the claimant had protected himself by electing to have insurance coverage for his business.

Board Member Gunn dissenting.

The majority proposes that case law prior to the 1990 amendments to ORS 656.273 made no distinction between intervening industrial incidents and intervening noncovered activities. In support of their assertion, the majority cites Barrett v. Union Oil Distributors, 60 Or App 483, 487 (1982). However, I find that contrary to the majority's reading of Barrett, that case does make a distinction.

As the majority noted, the court in Barrett stated that the law at that time provided that, "claimant must prove a worsened condition, a direct and compensable correlation to the previous compensable injury, and the absence of any intervening injuries or contributive exposures." Id at 487. (Emphasis supplied).

To a lay person, such as I, it seems obvious that had the court in Barrett intended to avoid making a distinction, as the majority suggests, the court would not have added "or contributive exposures." Rather, the court would have simply concluded the sentence after "any intervening injuries." Moreover, I find it folly on the part of the majority to apply pre-amendment legal construction to support post-amendment interpretations.

Further, I find the majority's reading of the sparse legislative history unjustly selective. A full reading of the legislative minutes demonstrates an intent contrary of the majority's.

The majority concludes that although Representatives Edmunson and Mannix refer to a hypothetical which involved a claimant falling from a roof, this discussion does not indicate that the legislature intended to only address supervening discrete injuries versus supervening incidents and activities. I disagree.

On May 3, 1990, Mr. Jerry Keene of the Workers' Compensation Defense Attorneys, testified that:

"On aggravations, the standard has not changed, 'material contributing cause' is still the standard for an aggravation claim, which is a natural worsening of the pre-existing compensable condition. This statute does not change situations where a worsening condition is caused by some supervening incident." (Emphasis supplied). Tape Recording, Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 8, Side B at 120.

In response, Representative Edmunson inquired if an on the job injury occurs and subsequently the worker falls off at roof, if the underlying claim would still be compensable. See Tape Recording, Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 8, Side B at 174. Mr. Keene indicated that under such circumstances, medical causation most likely would be in dispute. See Tape Recording, Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 8, Side B at 180.

Next, Senator Shoemaker inquired whether an injury would be compensable in a circumstance where a worker has degenerative arthritis and he bends over at work and his back goes out. See Tape Recording, Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 8, Side B at 237. Mr. Keene replied, "Yes." Further, Mr. Keene explained that "under this statute, the case goes on in the system until the doctor says the past injury pays [sic] absolutely no role in the treatment being rendered." See Tape Recording, Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 8, Side B at 240.

Considering the above testimony, I suggest that the majority stopped short in their perusal of the legislative transcripts. It is evident that a distinction was made.

The majority, unlike the legislature, declines to make a distinction between incidents and activities, because they reason that "such an interpretation of the statute would create different levels of proof for different aggravation claims." Further, the majority professes that there is no "legislative history nor rationale of which we are aware supports such a distinction."

The majority, however, ignores the basics in workers' compensation. The fact is, workers' compensation law has already created different levels of proofs in regard to initial claims. In accidental injury claims, a claimant's burden of proof is a preponderance of the evidence that an incident was a material contributing cause of his/her disability or need for medical services. See Harris v. Albertson's, Inc., 65 Or App 254, 256-57 (1983). In occupational disease claims, a claimant's burden of proof is that employment conditions were the major contributing cause of the disease or its worsening. ORS 656.802(2).

The majority in their fervor to assume that the statute is ambiguous and that a defect may lie in the act and not the reader, has forgotten an important legislative canon of construction: expressio unius est exclusio alterius, that is, if the drafter of a statute mentions one circumstance specifically, the implication is that other circumstances that just as logically could have been mentioned were intentionally omitted. Moreover, the majority has discounted another legislative canon, that words are construed according to their ordinary dictionary meanings.

In light of this, it is apparent that the majority has chosen to ignore the mandate of ORS 174.010. That statute provides:

"In the construction of a statute, the office of the judge is simply to ascertain and declare what is, in terms or in substance, contained therein, not to insert what has been omitted, or to omit what has been inserted; and where there are several provisions or particulars such construction is, if possible, to be adopted as will give effect to all." [Emphasis supplied]. See also Sullivan v. Kizer, 115 Or App 206 (1992); Whipple v. Howser, 291 Or 475 (1981).

Accordingly, it is not necessary for the majority to resort to alleged legislative history or rules of statutory construction when, as in the present case, the statute clearly and simply expresses the words intended to be enacted by the legislature, and thus, the intended effect of the statute. Any other reading of the statute would be authorizing the majority to insert into the statute what the legislature intentionally left out. For if the legislature had intended any other result, it would had said so.

The majority, citing Johnson v. Star Machinery Co., 270 or 694 (1974), finds that even if their proposed interpretation is not within the letter of the statute, they find that "when such [legislative] intent is manifest the courts must give it effect, even though to do so does violation to the literal meaning of the words." The problem with this contention is that the court in Johnson indicated that the literal meaning of the words of a statute may be skirted if the legislative intent is manifest. In the present case, the legislative intent is most certainly not "manifest," i.e., open and shut, conspicuous,

patent, etc. An irony, not lost on me, is that the majority conceded this point when they noted that the "legislative history surrounding enactment of this amendment to ORS 656.273 is limited."

The most disturbing thing about the instant case is the majority ignores the actual words of the statute. The majority opinion starts by telling us why we have and should now find another meaning for the word "injury." What the majority fails to tell us is what ambiguity in the language drives us to statutory construction.

The majority seems to want to reach that most elusive interpretative currency, legislative intent. However, here, the only way to reach the majority's conclusion is to detour around the words of the statute, ignore legislative history, and apply a suspected legislative intent which would remove any condition tainted by off-work illness or activity from the workers' compensation system. This equates to an interpretation of Senate Bill 1197 as providing for a stricter burden of proof than intended, i.e., to extract any and all compensation from injured workers unless a direct, indisputable, perhaps even beyond a reasonable doubt relationship exists between the compensable condition and work injury or disease.

Does that mean that Senate Bill 1197 also removed the case law maxim that the statute is to be liberally construed in favor of the injured worker? A reading of the majority's opinion puts the question into issue.

The majority is taking the same path mistakenly traveled by a previous Board. See Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991). The Board is interpreting the law to produce a result not reflected by the actual words of the statute. To make the majority's reasoning work we must move from an adjudicative body to a legislative group, writing in the words "disease" and "activity" to the statute. Perhaps this is even what some in the legislature wanted, but we have no business adding or subtracting from the actual words of law.

For my part, I will read the statute and continue to apply the most literal translation to the words. I will not, like the majority, reach out to implement some perceived legislative agenda. I cannot justify resolving any ambiguity without a sincere effort to discover actual legislative support, and where none exists, I will not insert a guess.

Finally, if the majority continues to apply presumed agendas, we will have changed a remedial statute, intended to give injured workers rights and benefits, to a penalty statute intended to punish workers for having been hurt at work. But this time, the rude wake up call is that it is no longer the worker, alone, who wears the albatross in this decision. We have now drawn the compensation net so tight that we make meaningless the protection provided in the workers' compensation system for employers.

To quote Representative Edmunson: "Everytime we make a work related condition noncompensable, we are exposing the employer to civil liability." See Tape Recording, Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 8, Side B at 149. Therefore, if that is not the intent of the law of "exclusive remedy," then I suggest that we avoid moving in that direction.

Board Member Hooton dissenting.

That I write separately signals no disagreement with the opinion of my distinguished colleague, Board Member Thomas Gunn. Indeed, in an earlier (and unpublished) draft of his dissent in this case, Board Member Gunn wrote "I leave to my more learned attorney colleague the legal analysis of why the majority has made the most grievous errors of law." Despite the fact that Member Gunn has demonstrated the capacity for fine legal analysis, the errors in the majority opinion are not only grievous but multitude. I write to touch upon the errors of reasoning not mentioned by Member Gunn.

In this case we embark again upon that most unique of all judicial functions, statutory construction. It is the goal of all statutory construction to discern and declare the intent of the legislature. Fifth Ave. Corp. v. Washington Cty by and through Board of County Commissioners, 282 Or 591 (1978). In seeking the intent of the legislature, however, some kinds of evidence are more persuasive and entitled to greater weight than are others. As the Supreme Court noted in State ex rel

Cox v. Wilson, 277 Or 747, 750 (1977), "[t]here is, of course, no more persuasive evidence of the purpose of the statute than the words by which the legislature undertook to give expression to its wishes." (Quoting U. S. v. Amer. Trucking Ass'ns., 310 US 534, 542-544, 60 S Ct 1059, 84 L Ed 1345 (1940). Accordingly we should heed the instructions of the court and "first look to the plain meaning of the words." Springer v. Bowen, Lee & Co., 60 Or App 60, 63 (1982).

The majority asserts that the term injury must be expanded to include the more general concept of "activities" to accomplish the intent of the legislature in its amendments to ORS 656.273. It argues that a restrictive definition of injury which includes only harmful incidents requires the addition of the term "accidental" to the language of ORS 656.273, and that the addition of that term is not supported by the legislative history. The majority is wrong.

"Injury" is defined as "an act that damages or hurts." Webster's Ninth New Collegiate Dictionary, 623 (1985). It is a general term within which fits a variety of particulars including, for example, "accidental" and "intentional". An accidental injury is an injury that arises unexpectedly or by chance. An intentional injury is an injury that results from a course of activity deliberately preconceived and pursued to produce a specific result. An intentional injury, however, is also unexpected to the individual injured and may, therefore, also be an accidental injury. Each is a smaller subset of the first. All of these forms of injury, however, have in common a harm arising from an act or incident.

The majority conceives the term in a different fashion. The majority focuses on the harm produced rather than the act itself and thus concludes that activities over an extended period of time, producing an anticipated and predictable consequence are also an injury, because the individual was harmed thereby. The distinction is between the injury inflicted and the injury sustained, or between the "how" and the "what." The assailant says "I hit him in the face." The victim says "He broke my nose."

The majority definition of "injury" is not without support. "Injury" is further defined as "hurt, damage or loss sustained." Webster's Ninth New Collegiate Dictionary, 623 (1985). Consequently, the English language has adopted the same word to describe both the "how" and the "what" in this instance. The question then becomes whether the statute provides a basis for distinguishing which of the two definitions is intended?

As with most words having multiple meanings, the context is the primary and best indicator of the use intended. This case is no exception. The statute reads "[h]owever, if the major contributing cause (the how) of the worsened condition (the what) is an injury..." In this statute then the definition intended is that definition which describes how the worsened condition came into being. The definition of "injury" which supplies the how is not the definition relied on by the majority, which focuses on the harm done, but rather, that definition that focuses upon the act which causes it.

As we can see, therefore, the plain meaning of the term "injury" is contrary to the reading the majority would use in the relevant portion of ORS 656.273(1). The plain meaning of the term "injury", in this instance, supports a reading of ORS 656.273(1) which requires a specific act or incident causing harm in addition to the harm already present by virtue of the compensable injury, to relieve the employer of liability for the consequences of a compensable injury. Assuming, however, that an ambiguity remains, the principles of statutory construction next require us to determine whether the term "injury" has a well-defined legal meaning, and if so, to apply that meaning to the statute. Reed v. Reed, 215 Or 91, 96 (1959).

Within the context of the Workers' Compensation Law the term injury does have a well-defined meaning. The law distinguishes between harms caused by a single act, or which occur in a discrete time period, and harms which result from activities pursued over time. The first are identified as injuries, the second as diseases. Despite the fact that the law makes this distinction, the majority argues that "the word 'injury' appears at numerous places in ORS 656.273 in a sense that includes both accidental injuries and occupational diseases", therefore, they argue that the term should be given a broad construction. Again the majority is wrong.

ORS 656.273 occurs in that portion of the Workers' Compensation Law that specifically relates only to injuries. That portion of the law is found at ORS 656.001 to 656.796. To the extent that ORS 656.273 applies at all to occupational diseases it does so by operation of ORS 656.804 which Lucky

requires that occupational diseases be treated as injuries, (as distinct from being injuries), for the purpose of providing benefits under the Workers' Compensation Law. ORS 656.273 is, despite the majority's assertion to the contrary, limited in its application only to workers who have suffered an "injury" as the result of a discrete event. It is only by virtue of ORS 656.804 that the terms of ORS 656.273 are applicable to the occupational disease law.

I have shown that a restrictive interpretation of the term "injury" is consistent with the common and dictionary definitions of the word, and with the overall use of the word both in ORS 656.273 and in the whole of the Workers' Compensation Law. Consequently, the most persuasive evidence of legislative intent supports a requirement of an act or incident causing harm additional to the harm caused by the compensable injury before the employer is relieved of his ongoing liability under ORS 656.273(1). The tenets of statutory construction advise, however, that the next step, when necessary, is to examine the policy of the statute as a whole. As Justice Rossman stated "[i]t is a maxim so well established as to require no citation to authority that a statute is to be construed as a whole and that effect must be given to the overall policy which it is intended to promote." Wimer v. Miller, 235 Or 25, 30 (1963). A restrictive interpretation of the term injury, in the present case, is consistent with the stated purposes and objectives of the Law. The interpretation offered by the majority is not.

The Workers' Compensation Law provides a clear and concise statement of the need for, and purpose and objectives of, the Workers' Compensation Law. That statement is found at ORS 656.012 which provides in pertinent part as follows.

(a) "The performance of various industrial enterprises necessary to the enrichment and economic well-being of all the citizens of this state will inevitably involve injury to some of the workers employed in these enterprises; and

(b) "The method provided by the common law for compensating injured workers involves long and costly litigation, without commensurate benefit to either the injured workers or the employers, and often requires the taxpayer to provide expensive care and support for the injured workers and their dependents."

(2) "In consequence of these findings, the objectives of the Workers' Compensation Law are declared to be as follows:

(a) "To provide, regardless of fault, sure, prompt and complete medical treatment for injured workers and fair, adequate and reasonable income benefits to injured workers and their dependents;" (Emphasis Added)

This statement of purpose and objectives preexisted the amendments to ORS 656.273 under consideration here, and was in no way changed by the act in which those amendments occur. We are therefore required to interpret the term injury in a manner consistent with the purpose and objectives of the Law. In determining how to accomplish this result, the Courts have noted that the Workers' Compensation Law is a remedial statute and is therefore to be liberally construed in favor of the injured worker. Stovall v. Sally Salmon Seafood, 306 Or 25, 38 - 39 (1988); Perkins v. Willamette Industries Inc., 273 Or 566, 571 fn 1 (1975). Its purpose is to transfer to the employer, as a cost of production, those costs, otherwise borne by the worker and by society as a whole, traceable to an occupational injury or disease. The statute requires the employer, and not the worker or the state, to bear those costs "to the greatest extent practicable." ORS 656.012 (2) (c). Consequently, provisions of the Law which provide an entitlement to benefits are to be read as broadly as possible, and those that limit that entitlement are to be read as narrowly as possible, consistent with the language of the Law.

When all else fails, proper statutory construction may depend upon consideration of the legislative history to divine intent. As Board Member Gunn has noted in his most incisive dissent, the legislative history, when taken as a whole supports a narrow reading of the word "injury" when applied to limit benefits. The majority asserts that the general intent of the legislature, however, supports the broadest possible reading. Without duplicating the effort put forth by Member Gunn, I wish to examine more closely the legislative history relied on by the majority to reach its unwarranted conclusion.

The first cited statement of legislative history is a portion of the testimony of Representative Mannix that "in most of these circumstances right now the workers' comp system under aggravation claims is paying benefits for things that ought not to be covered by workers' compensation." Tape Recording, House Special Session, Floor Debate, May 7, 1990, Tape 2, Side A. This particular piece of legislative history indicates that Representative Mannix sought to exclude benefits for things that ought not to be covered. However, taken out of context, the quotation doesn't provide guidance as to what "ought not" means. The only indication is in the portion excluded from the quote which describes what "these circumstances" are. The circumstances under discussion which gave rise to the above referenced quotation involved, not activities, but specific incidents. The majority conveniently ignores the referent.

The majority goes on to quote Senator Kitzhaber on a subject not specifically related, but in support of a general proposal that the legislature intended to remove from the workers' compensation system those costs which rightfully belonged elsewhere.

The problem with this piece of legislative history is that it does not indicate what things rightfully belong outside the system. In reaching its conclusion the majority has taken upon itself the task of establishing, as a matter of policy, that if any noncompensable "activities"¹ cause a worsened condition claimant ought not to be entitled to recover under the Workers' Compensation Law. Establishing such broad ranging policy is a matter for a duly elected legislature, not this Board. Dilger v. School District, 222 Or 108, 112 (1960).

If Senator Kitzhaber's statement is to be taken literally as an expression of the general intent of the legislature, the phrase "due primarily" as construed by this majority should mean that the material standard of causation is dead in the Workers' Compensation Law. This is consistent with remarks that Senator Kitzhaber made elsewhere in the record.

"I believe that this bill is consistent with my belief that if the work place is the major contributing cause of the problem, then the care should be provided through and paid for by the workers' compensation system. But I also believe that if something else, something outside the work place is the major contributing cause, then the responsibility is a larger social responsibility and should be cared for and provided through our regular health care system." Special Session, May 7, 1990, Senate Floor Debates, Tape 3, Side A; Transcript of Senate Floor Debate at pages 4, 5.

There are three identifiable reasons for rejecting the analysis offered by Senator Kitzhaber. First, his opinion is inconsistent with statute and we have already rejected this position in Robert E. Leatherman, 43 Van Natta 1677 (1991); Mark N. Wiedle, 43 Van Natta 855 (1991); and, Bahman Nazari, 43 Van Natta 2368 (1991). Second, the opinion focuses only on the entitlement to medical services and does not consider the social consequences of a denial of time loss benefits based on a higher burden of proof. Third, and most significant, the court has already established that the testimony of individual legislators is not competent for the purpose of determining legislative intent. Bryson v. Public Employee Retirement Bd, 45 Or App 27, 33 (1980); Murphy v. Nilson, 19 Or App 292, 296 (1974).

If we must examine the general intent of the legislature, let's first determine clearly what it is. There is a prevalent notion on this Board and in the workers' compensation insurance community that the sole intent of the legislature was to reduce benefits then being paid to injured workers. An unprincipled rush to complete the legislative task by further restricting the rights and benefits of injured

¹ It is interesting to note that the majority argues that the statutory definition of a "compensable" injury has no application in declaring the meaning of the term "injury" in the phrase under discussion here, but rewrites the statute to provide relief for the consequences of "noncompensable" activities. It appears that the term "compensable" is applicable as a modifier only in the negative.

workers is an abomination to be avoided at all cost.² The legislature did what it did and no more! In seeking the general intent of the legislature we should be mindful of the balancing expressions of that intent by those such as Representative Kotulski who questioned "Do we have some way of determining or monitoring over the next couple of years to determine what those costs will be? So that we are not just shifting from an employer based insurance system to a taxpayer based insurance system." Special Session, May 7, 1990, House Floor Debates, Transcript page 48. We might also consider the vast majority of senators and representatives who indicated their belief that they were passing legislation that cut costs to employers while increasing benefits to injured workers.

In further support of the narrow reading of "injury" as an act or incident as proposed by the minority of the current Board, we note that the majority opinion is founded upon an ill-concealed inconsistency which fatally weakens its position. The majority argues that the minority wishes to add language to the statute, an act which it disdains. The majority, however, must also add to the statute to reach the present result.

ORS 656.273 provides in pertinent part as follows.

"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.....However, if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable." (Emphasis added).

In this case, the activity which the majority contends is the major cause of the claimant's worsened condition is activity specifically occurring within the course of claimant's employment. That should be the end of the story, regardless of whether the activity fits within the scope of the term "injury". How then does the majority conclude that the claimant's worsening is not compensable?

"Employment" is a general term, but it is not an ambiguous one. "Employment" is that activity in which each of us engages with the hope of producing either wages or profit. Within the general, many particulars reside; two of which are especially significant to the present claim; "self employment" and "covered employment." These two particular forms of employment are significant here because self employment is quite often not covered employment. The sole distinguishable basis for the conclusion that claimant's employment activities in this case are not sufficient to remove the consequences of those activities from the consideration of the limitation in ORS 656.273 is because they derive from noncovered self employment. In other words, the majority apparently reads ORS 656.273 as follows.

"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 However, if the major contributing cause of the

² If the history of SB 1197 indicates any general intent it was to reach a compromise agreement between labor and management that provided essential and necessary medical services and income benefits while curtailing unnecessary care and unnecessary litigation. As a consequence of compromise, liability was restricted in situations where the relationship between the employment and the "injury" was less than direct. The essential term here, however, is compromise. In determining the legislative intent a quick indicator whether a supposed general intent truly represents the intent of the legislature is to ask whether both sides to a compromise bill would have agreed to such a term or would have held such a general intent. I would submit that it was not the general intent of the labor representatives responsible for drafting proposed legislation to so restrict aggravation claims as to make them nearly impossible to establish. If labor would not have supported such an intent, it is unlikely that it could have played any role in the final compromise that resulted in SB 1197. A good indicator of the probability of labor supporting such an intent is evident in this opinion simply by looking at the signatories to the majority and dissenting opinions. Both labor representatives have elected to dissent. I would point out that there is no hope that compromise legislation can work effectively unless the administrative body responsible for implementing it is equally attuned to the component of compromise necessary to obtain passage. Neither the Department of Insurance and Finance nor this Board has yet indicated a willingness to support the essential compromise necessary to obtain this piece of reform legislation. Rather, with few exceptions, SB 1197 has suffered an administrative reinterpretation that advances only the employer's interest.

worsened condition is an injury not occurring within the course and scope of 'covered' employment, the worsening is not compensable."

The basis for this additional language is apparent from the discussion above. The majority is locked into an analysis of entitlement that is based, not upon the language of the statute, but upon some nebulous consideration of what "ought" or "ought not" to be covered. Certainly, an injury occurring within the scope of employment should be covered by workers' compensation benefits. Therefore, it would be inappropriate to prevent the accrual of those benefits based on the language of ORS 656.273(1).

I have a great deal of sympathy for the reasoning that leads to this conclusion. But the simple fact is that it is inconsistent with the reasoning demonstrated elsewhere in the majority position. This is demonstrable by a simple analogy. Let us, momentarily, assume that claimant is not self-employed, but employed by another to do the very same work that contributed to his worsened condition here. Let us also assume that there is no prior compensable injury, but that claimant comes to that employment with a preexisting noncompensable condition including cervical strain and disc herniation. Under these circumstances claimant's disability and need for medical treatment as demonstrated here would not be compensable. His worsened condition does not involve a worsening in the underlying pathology, consequently he would not be entitled to benefits under the occupational disease law. The worsening also does not derive from a discrete incident or arise within a discrete time period. Consequently, claimant would not have a compensable injury under the Law. No event, or pathological change, has occurred that would signal an impact of claimant's employment sufficient to support the proposition that claimant ought to be relieved of his responsibility for his preexisting condition by transferring future responsibility to his employer. Consequently, even if claimant's worsening occurred as a result of covered employment there are not sufficient indicia here that the claim "ought" to be covered by the workers' compensation system under the majority's broad reading of the limitation in ORS 656.273(1).

This is not to say, however, that we disagree that the term "employment" actually refers to "covered employment". We do agree. But based on the analysis above, we would suggest that the limitation to covered employment provides an additional indication in the statute what "ought" and "ought not" to be covered by the workers' compensation system. If we read employment as covered employment and injury as accidental injury, ORS 656.273(1) would except from the provisions limiting aggravation claims those injuries that would produce liability in another employer within the system.

Just as we can conclude that the absence of a specific event causing a symptomatic worsening of a preexisting condition, or the absence of pathological change traceable to employment exposure over time supports the conclusion that there are no indicia of liability that would make an employer initially responsible for a preexisting condition, it is appropriate to conclude that the absence of a specific event or pathological change supports the conclusion that there are not sufficient indicia of liability elsewhere to justify relieving an employer of responsibility for a condition that was originally caused by employment.

The minority position is that the statute indicates that the legislature intended to relieve employers of liability for a worsened condition only in those circumstance where it is clear that a responsibility producing event has occurred which is sufficient to justify that relief. This claim does not reflect such an event or change in condition.

Finally, even if the majority's declaration of the intent of the legislature is correct and appropriate, its application of law to the present facts is wholly incorrect. The majority relies exclusively on the opinion of Dr. LaFrance regarding causation. That opinion does not support the conclusion that claimant's self-employment activities are the major cause of a worsened condition.

Claimant experiences a cervical strain and herniation resulting in chronic pain and an inability to sustain certain postural conditions for long periods. When these postural conditions are encountered, claimant can expect to experience an increase in symptomatology from the underlying disease process which was caused solely by his employment. Postural conditions contribute only to an exacerbation of symptoms, not to any change in the condition causing symptoms to occur. As Dr. LaFrance indicated, "...most likely the [compensable injury] would very typically have caused cervical strain and injury and appears to be most likely the process that is responsible for any herniation and continued pain."

(Emphasis added). In Robert E. Leatherman, supra we concluded that ORS 656.273(1) does not inquire as to the cause of the worsening but examines the cause of the condition as worsened. Here there is only a symptomatic worsening, the condition itself has not worsened. Further the underlying compensable condition is a necessary element in causation because it creates the susceptibility to symptomatic aggravation with certain postural requirements. Under these circumstances it is inappropriate to conclude that the postural requirements of claimant's self employment are the major cause of his "worsened" condition. This is even more apparent when we consider that the symptomatic exacerbation did not occur quickly in response to a discrete event, but over a long period of time.

If the majority is correct that a symptomatic worsening arising from the effects of mere postural requirements is sufficient to relieve the employer from liability on a workers' compensation claim, there is no longer any need for ORS 656.273. Aggravation claims continue to exist in only the rarest of circumstances. We are unable to conceive of a situation in which the insurer could not find some activity or condition that is causally related to the increased symptoms in precisely the manner that claimant's self employment is related to the present claim. The majority provides no test or limitation which preserves compensability in any circumstance.

I acknowledge that the majority cites Wilson v. Workers' Comp. Comm'r, 328 S.E. 2d 485 (W. Va. 1984) in a manner that suggests such a test. However, it is equally apparent that the majority does not follow the test provided there in resolving the present case. That case states, as quoted by the majority, that "[i]f, however, a subsequent aggravation of the initial injury arises from an independent intervening cause not attributable to the claimant's customary activity in light of his condition, then such aggravation is not compensable." (Majority Opinion, fn 2). An independent intervening cause is a cause which bears no relationship to the compensable condition and which could have produced disability or a need for medical services even in the absence of the compensable condition. The identification of an independent intervening cause provides evidence sufficient to conclude that responsibility "ought not" to continue in the workers' compensation system. It is present where there is a discrete event. It is not present when, as here, there is an increase in symptoms traceable to the compensable condition resulting from claimant's customary activities (i.e., his self employment) in light of that condition. Wilson wholly supports the minority view that a discrete act or event must occur before the employer's liability for an aggravation is overcome. It does not, in any way support the majority position that claimant's non-compensable activities, without any event or pathological worsening, is sufficient. Indeed, it argues directly against such a result.

The referee in this case correctly determined that a specific act or incident is a necessary precondition to application of the limitation present in ORS 656.273(1). In the absence of such an act or incident, the claimant need only show a material causal relationship to establish the compensability of his worsened condition. Robert E. Leatherman, supra. Because the majority ignores the express language of the statute and indulges in legislation rather than adjudication, supplanting its own judgment of what "ought" to be covered for the considered policy decision of the legislature, I must dissent.

In the Matter of the Compensation of
CINDY M. HACKENBURG-GARCILAZO, Claimant
WCB Case Nos. 91-05648 & 91-03872
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Roberts, et al., Defense Attorneys
Roderick Peters (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerland.

The SAIF Corporation, as the insurer for OHSU (SAIF/OHSU), requests review of that portion of Referee Poland's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS). Claimant cross-requests review of that portion of the order that declined to award her attorney an assessed attorney fee regarding a rescission of a disclaimer of responsibility by SAIF, as the insurer for Milwaukee Convalescent Hospital (SAIF/Milwaukee). On review, the issues are compensability and attorney fees.

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

Claimant has an accepted 1988 claim for left wrist DeQuervain's tenosynovitis with SAIF/Milwaukee. SAIF/Milwaukee issued: (1) a disclaimer of responsibility of claimant's left DeQuervain's tenosynovitis and bilateral CTS; (2) a denial of compensability of claimant's condition as an aggravation of the accepted tenosynovitis condition; and (3) a denial of responsibility and compensability for claimant's bilateral CTS. (Exs. 42, 52, 58A). At hearing, claimant acknowledged that she was not contending that her accepted tenosynovitis condition had worsened. As a result, SAIF/Milwaukee withdrew its aggravation denial and its disclaimer of responsibility as it related to the tenosynovitis condition.

The Referee found that claimant's attorney was not entitled to an attorney fee for SAIF/Milwaukee's withdrawal of its denial of claimant's current symptoms as an aggravation of her accepted tenosynovitis condition. We adopt the Referee's reasoning and conclusions regarding that issue.

In addition, at hearing and on review, claimant argued another basis for entitlement to an attorney fee; that basis was SAIF/Milwaukee's rescission of the disclaimer of responsibility for her tenosynovitis condition. However, because a notice of intent to disclaim responsibility is not a denial of compensation, claimant's attorney is not entitled to an assessed fee. ORS 656.386(1); David Jones, 44 Van Natta 1752 (1992); see also Multnomah County School Dist. v. Tigner, 113 Or App 405 (1992).

Claimant is entitled to an assessed attorney fee for prevailing over SAIF/OHSU'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 SAIF/OHSU. 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 14, 1992 is affirmed. For services on review, concerning the compensability issue claimant's attorney is awarded an assessed fee of \$1,000, to be paid directly to claimant's attorney by the SAIF Corporation, as the insurer for OHSU.

In the Matter of the Compensation of
ROGER D. HART, Claimant
WCB Case Nos. 90-19506 & 90-19507
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members en banc.

Claimant requests review of Referee Crumme's order that upheld the self-insured employer's denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Because claimant filed his hearing request after May 1, 1990, and the hearing was convened after July 1, 1990, the 1990 amendments to the Workers' Compensation Law apply to this case. See Or Laws 1990 (Special Session), ch. 2, §54; Ida M. Walker, 43 Van Natta 1402 (1991).

We begin with a brief summary of the facts. Claimant compensably injured his low back in July 1988. The injury, diagnosed as a compression fracture of the L1 vertebra, was accepted by the employer. The injury claim was closed by Determination Order in August 1989 with a 7 percent unscheduled permanent disability award. In July 1990 claimant reinjured his low back while lifting a box at home. Dr. Sacamano diagnosed a thoracolumbar strain, for which claimant filed the aggravation claim.

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).

We are persuaded that claimant experienced an increase in low back symptoms following the July 1990 lifting incident, rendering him less able to work than at the time of the August 1989 Determination Order. Claimant testified that, although he continued to have occasional low back pain after returning to work following the 1988 injury, he was able to work and did not seek treatment until the 1990 incident. (Tr. 9, 13). Following that incident, he experienced more severe low back pain with numbness radiating to the left leg, which rendered him unable to work and for which he sought treatment. (Ex. 22; Tr. 10-11, 13, 15). Accordingly, we find that claimant has established a worsened low back condition since the last award of compensation.

We also find that claimant has proved the worsened condition with medical evidence supported by objective findings. "Objective findings" includes 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. See Georgia Pacific Corporation v. Ferrer, 114 Or App 471 (1992); Suzanne Robertson, 43 Van Natta 1505 (1991). Following the 1990 incident, claimant returned to Dr. Sacamano with complaints of increased low back and left leg symptoms. Based on his examination, as well as diagnostic studies and a consultation with Dr. Guyer, Dr. Sacamano diagnosed an "aggravating thoracolumbar strain." (Ex. 34, 36-19, 36-20). We conclude that is sufficient medical evidence supported by objective findings.

We now proceed to the question of statutory interpretation which determines the outcome of the present dispute. In relevant part, ORS 656.273(1) provides:

"(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. * * * However, if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable." (Emphasis added).

The underscored language of the statute was added by the 1990 Legislature. See Or Laws 1990 (Special Session), ch. 2, § 18. Under former ORS 656.273(1), a claimant established the compensability of a worsened condition by proving that the compensable injury is a material contributing cause of the worsened condition. See Grable v. Weyerhaeuser Company, 291 Or 387, 400-01 (1981) (A worsened condition resulting from both a compensable injury and a subsequent off-the-job injury is compensable if the compensable injury is a material contributing cause of the worsened condition).

We have held that under the 1990 amendments to ORS 656.273(1), the test for establishing a compensable worsening remains the "material contributing cause" test. Robert E. Leatherman, 43 Van Natta 1677 (1991). In Leatherman, however, there was no allegation or evidence of an off-the-job injury. Subsequently, in Elizabeth A. Bonar-Hanson, 43 Van Natta 2578 (1991), aff'd mem Bonar-Hanson v. Aetna Casualty Company, 114 Or App 233 (1992), we stated that a compensable worsening is generally established by the "material contributing cause" test, but if an off-the-job injury is the major contributing cause of the worsened condition, the worsening is not compensable. See also Annette M. Cochran, 43 Van Natta 2628 (1991).

Here, the record contains conflicting medical evidence concerning whether claimant's current worsened condition is causally related to his compensable injury or the off-the-job lifting incident. Dr. Hazel concluded that the compensable injury had not contributed to claimant's worsened condition. Moreover, Dr. Hazel attributed claimant's worsened condition to the off-the-job incident.

The Referee concluded, and we agree, that Dr. Sacamano's opinion is the most persuasive evidence on the question of causation. We adopt the Referee's reasoning on that point.

Dr. Sacamano opined that both the 1988 compensable injury and the July 1990 off-the-job injury were significant factors contributing to claimant's current condition. (Exs. 36-11, 36-20, 36-21). Thus, it is clear that the compensable injury was a material contributing cause of the worsened condition.

However, Dr. Sacamano could not determine which, if either condition, contributed more to the worsening than the other. Thus, the record does not establish that the July 1990 off-the-job injury is the major contributing cause of the worsening. Rather, both the 1988 compensable injury and the July 1990 off-the-job injury have been shown to be material contributing factors.

Claimant observes that under the express language of amended ORS 656.273(1), an employer is shielded from liability for an otherwise compensable aggravation "if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment." Therefore, claimant argues that the quoted language creates an "affirmative defense" which, in the present case, the employer failed to establish by the evidence.

The Referee rejected claimant's argument. Relying on ORS 656.266, the Referee concluded that claimant had the burden to prove that the off-the-job injury was not the major contributing cause of claimant's worsened condition. Finding that claimant did not carry that burden, the Referee concluded that the aggravation claim is not compensable. We disagree with the Referee's reasoning and conclusion.

ORS 656.266 generally places on the worker "[t]he burden of proving that an injury or occupational disease is compensable and of proving the nature and extent of any disability resulting therefrom." However, we believe that the appropriate analysis must begin with ORS 656.273(1), for the principal question here is not who has what burden of proof. ORS 656.273, is a substantive provision that governs aggravation claims. In plain words, it provides that an employer is authorized to deny an aggravation claim, and this Board must uphold such a denial, "if the major contributing cause of the worsened condition is an injury not occurring in the course and scope of employment."

Given the explicit nature of this statutory direction, we must reject the employer's argument that, under ORS 656.273(1), the claimant has the burden of proving that the off-the-job injury is not the major contributing cause or that the compensable injury is the major contributing cause. In doing so, we recognize that under ORS 656.266, generally the injured worker has the burden of proving compensability.¹ We also recognize, however, that only the employer or insurer would have an interest in proposing that the major contributing cause of the worsened condition is an off-the-job injury; and to that extent, the effect, if not the purpose, of the explicit language of ORS 656.273(1) is to assign to the employer the burden of proving facts that only the employer would have reason to propose.

In interpreting a statute that is explicit in its language, it is axiomatic that we cannot insert what has been omitted or omit what has been inserted. Furthermore, where there are several provisions, such a construction is to be adopted as will give effect to all. It is our duty to adopt a construction which comports with these basic principles.

Reading ORS 656.266 and amended ORS 656.273(1) together, we do not find any necessary or irreconcilable conflict between them. Rather, they can be read harmoniously, in a manner that carries out their respective purposes without doing damage to the language of either. We conclude that under ORS 656.266, claimant has the burden of proving that the compensable injury is a material contributing cause of the worsened condition. Elizabeth A. Bonar-Hanson, supra. If, pursuant to ORS 656.273(1), the employer denies the aggravation claim on the grounds that an off-the-job injury is the major contributing cause of the worsened condition, as the proponent of that fact, the employer has the burden of proving it.

Here, claimant carried his burden by proving, through Dr. Sacamano's opinion, that the compensable injury is a material contributing cause of the worsened condition. Under amended ORS 656.273(1), the question becomes whether the employer carried its burden of proving its assertion that the off-the-job injury is the major contributing cause of the worsened condition. On this record, the employer failed to carry its burden. As previously discussed, although Dr. Sacamano opined that the compensable injury and the off-the-job injury were both significant factors, he could not determine

¹ Although the injured worker generally has the burden of proof on questions of compensability, there are exceptions to this basic rule. Some are clearly expressed by statute, others are not. For example, to support a "back-up" denial issued under amended ORS 656.262(6), that statute expressly states that the employer has the burden to prove by clear and convincing evidence that the claim is not compensable or that the paying agent is not responsible. Additionally, ORS 656.802(4) expressly states that the employer has the burden to prove by clear and convincing evidence that a condition which qualifies for the "firefighter's presumption" is unrelated to the firefighter's employment.

Other exceptions to the rule are not expressly provided by statute. For example, the courts have held that an employer has the burden to prove that it was prejudiced by a claimant's failure to timely file notice of a claim. See ORS 656.265(4)(a); Inkley v. Forest Fiber Products Co., 288 Or 377, 348 (1980); Satterfield v. Compensation Dept., 1 Or App 524, 529 (1970); Aetna Casualty Co. v. Kupetz, 106 Or App 670, 675 (1991). There is also the "alcohol and unlawful drugs" exception which was added by the 1990 Legislature to the definition of a compensable injury. ORS 656.005(7)(b)(C) states:

"(b) 'Compensable injury' does not include:

"(C) Injury the major contributing cause of which is demonstrated to be by clear and convincing evidence the injured worker's consumption of alcoholic beverages or the unlawful consumption of any controlled substance, unless the employer permitted, encouraged or had actual knowledge of such consumption."

Since only the employer has an interest in proposing, pursuant to this statute, alcohol use or controlled substance abuse by the worker, we conclude that the employer, as the proponent of the asserted fact, has the burden to prove the truth of its assertion. In this respect, this statute is similar in purpose and effect to the language in dispute in ORS 656.273(1).

which, if either injury, was the major contributing cause of the worsened condition. There is no other medical opinion in the record on this question of causation, except the opinion of Dr. Hazel, which we do not find persuasive. Therefore, the employer's denial must be set aside.²

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 fee for claimant's counsel's services at hearing and on review concerning the aggravation issue is \$6,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs, statement of services submitted, and the hearing record), the complexity of the issue, the value of the interest involved, and the risk in this case that claimant's counsel might go uncompensated for his work.

ORDER

The Referee's order dated April 22, 1991 is reversed. The self-insured employer's October 2, 1990 aggravation denial is set aside, and the claim is remanded to the employer for further processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of \$6,000, to be paid by the self-insured employer.

2 We acknowledge there is some legislative history concerning the meaning of amended ORS 656.273(1). Representative Mannix said the following on May 7, 1990, House of Representatives, Special Session (Tape 2, Side A):

"In regard to aggravations. The standard right now is whether or not there's been some material contribution to worsened condition. The best example I can come up with is, you've got a low back strain and your back is still hurting you, on a weekend at home you go up on the roof and you are trying [to] reroof your own house, and you fall off. Those resulted medical services involving that low back strain are still considered compensable and you probably got an aggravation a worsening under the workers' comp system. What we're saying here is the worsening is going to have [to] be something which - - where the industrial injury is a major contributing cause of the worsening. It sets up tougher standards to reopen your claim on an aggravation basis. No doubt about it. But in most of these circumstances right now the worker's comp system under aggravation claims is paying benefits for things that ought not be covered by workers' compensation." (Emphasis added).

As a general rule, it is appropriate to consider legislative history on a question of statutory interpretation, to the extent it has relevance to the question. However, legislative history cannot control the question where the legislator's particular statement directly conflicts with language of a statute that is so plain and unambiguous that it is capable of only one interpretation. Here, that is the problem with Representative Mannix's statement. Contrary to his statement, ORS 656.273(1) plainly states that "if the major contributing cause of the worsened condition is an injury not occurring in the course and scope of employment, the worsening is not compensable." Thus, the statute does not say that where any off-the-job injury occurs, the claimant must prove that the compensable injury is the major contributing cause. Under the circumstances, we conclude that the language of the statute controls.

Board Members Brazeau, Kinsley and Neidig dissenting.

Because we disagree with the majority that claimant's claim is compensable, we respectfully dissent.

Our primary disagreement with our colleagues involves their reasoning regarding the allocation of the burdens of proof inherent in ORS 656.273(1). It is a disagreement that determines the outcome of this case.

We agree with the majority that generally, in order to establish a compensable claim for aggravation under ORS 656.273(1), a worker has both the initial burden of presenting evidence and the ultimate burden of persuasion that the compensable injury is a material contributing cause of the worsened condition. The majority further concludes, however, that where the employer asserts that the worker's aggravation claim is not compensable on the ground that an off-the-job injury is the major

cause of the worsened condition, the employer has the ultimate burden of persuasion in that regard by way of proving an "affirmative defense." We disagree.

As the majority itself notes, ORS 656.266 expressly places on the worker "[t]he burden of proving that an injury or occupational disease is compensable and of proving the nature and extent of any disability resulting therefrom." We conclude that when this statute is read together with ORS 656.273(1), the worker has the initial burden of presenting evidence that the compensable injury is a material contributing cause of the worsened condition. We further conclude, however, that if claimant carries his initial burden, the employer must, in turn, present evidence that an off-the-job injury is the major contributing cause of the worsened condition. See ORS 183.450(2) ("The burden of presenting evidence to support a fact or position in a contested case rests on the proponent of the fact or position"). The employer carries this burden by making a prima facie showing that the off-the-job injury is the major contributing cause of the worsened condition. Upon such a showing, the ultimate burden of persuasion rests with the claimant to establish the compensability of the claim for aggravation. Claimant may carry this burden by persuading the factfinder that the off-the-job injury is not the major contributing cause of the worsening or that the compensable injury is the major contributing cause. We conclude that this interpretation serves, more than any other, to effectuate the purpose and language of both ORS 656.266 and 656.273(1).

Here, claimant carried his initial burden by presenting evidence that his compensable injury is a material contributing cause of the worsened condition. We agree with the majority that Dr. Sacamano's opinion is persuasive in that regard. The burden then shifted to the employer to present evidence sufficient to establish a prima facie case that claimant's off-the-job injury is the major contributing cause of the worsened condition.

We believe that the employer established a prima facie case through the opinion of Dr. Hazel, who treated claimant on several occasions after the July 1990 off-work injury. Dr. Hazel opined that the compensable injury did not contribute at all to the worsened condition as a causative factor, but rather, that the off-the-job injury was the sole cause of the condition. Once this prima facie evidence was presented, we believe that the burden shifted back to claimant to persuade the factfinder, by a preponderance of the evidence, either that the off-the-job injury was not the major contributing cause or that the compensable injury was the major contributing cause.

We believe that claimant failed to carry his ultimate burden of persuasion. As previously discussed, although Dr. Sacamano opined that the compensable injury and the off-the-job injury were both significant factors, he could not determine which injury was the major contributing cause of the worsened condition. Therefore, the Referee properly concluded that claimant failed to establish the compensability of the aggravation claim.

Because we would affirm the Referee's order, we respectfully dissent.

October 28, 1992

Cite as 44 Van Natta 2193 (1992)

In the Matter of the Compensation of
DANIEL R. JORDISON, Claimant
WCB Case No. 91-12440
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Davis & Bostwick, Defense Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The noncomplying employer requests review of Referee Crumme's order that dismissed its request for hearing concerning SAIF's acceptance, on its behalf, of claimant's 1988 injury claim. In its brief, the employer objects to the amount of the Referee's attorney fee award. On review, the issues are compensability (subjectivity) and attorney fees. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability (Subjectivity)

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

Relying on Blain v. Owen, 106 Or App 285 (1991), and characterizing the issue as one concerning "compensability," the noncomplying employer contends that it is not precluded from contesting claimant's subject worker status. We disagree.

Pursuant to former ORS 656.054(1) and ORS 656.283(1) there was not a time limitation on when a noncomplying employer could request a hearing on "compensability." See Blain v. Owen, supra. However, whether there is any time limitation applicable to the employer's hearing request is not the problem.

Here, the issue of whether claimant was a subject worker was previously litigated to final judgment in the compliance proceeding. The Referee's determination that the employer was noncomplying was based on his finding that claimant was a subject worker. (Ex. 5). Therefore, although there is no time limitation in which the noncomplying employer may contest "compensability" on other grounds, (e.g., course and scope of employment, medical or legal causation), the employer is precluded from relitigating claimant's subject worker status. In other words, because of the holding in the earlier compliance proceeding, claimant is a subject worker who may file a claim against the employer for benefits. Lasiter v. SAIF Corporation, 109 Or App 464 (1991).

Attorney Fees

The noncomplying employer contends that the Referee's attorney fee award to claimant's counsel for services at hearing is excessive. We disagree.

After our review of the record and considering the factors set forth in OAR 438-15-010(4) we agree with the Referee's attorney fee award. In reaching this conclusion, we note that claimant's attorney spent considerable time researching and preparing pretrial motions which raised and successfully argued complicated legal issues. Considering the legal services provided and the complexity of the issues, as well as the benefit secured for claimant, we conclude that the amount of the fee awarded (\$1,750) was appropriate.

Attorney Fees/Board Review

Claimant is entitled to an assessed attorney fee for prevailing over the employer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability (subjectivity) issue is \$1,050, to be paid by the SAIF Corporation on behalf of the noncomplying employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 8, 1992 is affirmed. For services on review concerning the compensability (subjectivity) issue, claimant's attorney is awarded an assessed fee of \$1,050, payable by the SAIF Corporation on behalf of the noncomplying employer.

In the Matter of the Compensation of
VIVIAN CHAPMAN, Claimant
WCB Case No. 91-01701
ORDER ON REVIEW
Jeff Carter, Claimant Attorney
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Westerband and Brazeau.

Claimant requests review of that portion of Referee Herman's order that upheld the self-insured employer's denial of her current right knee condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant has a preexisting degenerative arthritis condition, from which she has suffered since at least March 9, 1987. On that date, she had surgery for the condition: a partial medial meniscectomy of the tibia and femur.

On March 7, 1988, claimant, while in the course of employment, twisted her right knee as she tried to leave a cooler, and fell, injuring her knee in the process. The employer accepted claimant's right knee injury claim.

The claim was closed by a Determination Order dated January 4, 1989. Claimant was awarded 33 percent scheduled permanent disability.

Claimant's right knee condition worsened soon after issuance of the Determination Order. She filed an aggravation claim on March 7, 1989.

On May 9, 1989, Dr. Holm Neumann, claimant's treating physician, opined in support of her claim, that claimant's condition had materially worsened since the claim was closed in January 1989; that claimant was not medically stationary; and that he recommended diagnostic arthroscopy and possible definitive surgery. (Ex. 10-A). In subsequent reports, he conceded that claimant had preexisting degenerative arthritis. However, he believed that the March 7, 1988 compensable injury was a material contributing cause of the progressive worsening. He opined that the rapid degeneration of the right knee condition substantiated his diagnosis that she suffered from post traumatic arthritis as a result of the 1988 compensable injury. (Ex. 13A-2).

Drs. William McHolick, Faulkner Short, and Todd Lewis, independent medical examiners, disagreed with Dr. Neumann's understanding of claimant's problem. They opined that claimant's worsened right knee condition represented solely the natural progression of her preexisting degenerative arthritis, and that the 1988 compensable injury had nothing to do with claimant's problem. They believed that a total right knee replacement would be necessary. (Ex. 13A-2).

On October 19, 1989, the employer denied the aggravation claim on the basis of the reports from the independent medical examiners. The denial letter stated that "your current condition is wholly unrelated to your industrial injury of 3/7/88 and that your original injury does not materially contribute toward your disability or need for medical treatment." (Ex. 15).

On November 6, 1989, Dr. Neumann performed a total right knee replacement. (Ex. 16). In a report dated December 5, 1989, he stated that claimant's compensable injury was a material contributing cause of her need for a total right knee replacement. He explained that a "condition of post traumatic arthritis can be associated with a tear of a meniscus, and I feel she tore her meniscus at the time of her industrial injury." He further explained that the total right knee replacement became necessary because conservative treatment had failed to manage the problem. (Ex. 18A-1).

Once again, Drs. Lewis and Short disagreed. They attributed the cause of the worsening and need for a total right knee replacement to the preexisting degenerative arthritis. (Exs. 18 and 19).

Claimant appealed the aggravation denial, and a hearing was held on January 5, 1990. By Opinion and Order dated January 31, 1990, Referee Irving set aside the denial and remanded the aggravation claim to the employer for acceptance and processing. This order was not appealed, and thus became final by law. Pursuant to the order, the employer paid for the total tight knee replacement and for all post-operative treatment claimant received for the knee until January 31, 1991. (Ex. 33-25).

On July 25, 1990, orthopaedic surgeon, Dr. Hunt, performed an independent medical examination of claimant at the request of their employer. Dr. Hunt's opinions will be discussed below.

On January 31, 1991, the employer issued a denial of claimant's current condition on the grounds that the major contributing cause of the condition and her need for treatment of the right knee was the preexisting degenerative arthritis.

The claim was closed by Determination Order dated April 25, 1991. Claimant requested reconsideration. On August 29, 1991, the Department issued an Order on Reconsideration affirming the Determination Order in all respects.

On September 27, 1991, claimant was examined by medical arbiter, Dr. Thad Stanford, on behalf of the Department.

Drs. Hunt and Stanford opined, and we find, that in totally replacing the right knee, Dr. Neumann surgically removed the areas affected by the preexisting degenerative arthritis. Hunt and Stanford also opined, and we find, that the treatment claimant received for the right knee since the surgery in November 1989 was directly related to and necessitated by the surgery, which was the major contributing cause of the need for the treatment in question. (Ex. 33-9 to 12; Ex. 35-7 to 10).

CONCLUSIONS OF LAW AND OPINION

The employer contends that it may now contest the compensability of the November 1989 total knee replacement and the further treatment necessitated by that surgery, because compensability of the total knee replacement was allegedly not litigated to final judgment in the prior aggravation claim case. Furthermore, the employer contends that since the major contributing cause of the condition which required the surgery was claimant's preexisting arthritis, the surgery and the subsequent treatment are not compensable under ORS 656.005(7)(a)(B). We reject the employer's premise and therefore disagree with its ultimate conclusion. On our review of the record, we find that the compensability of the surgery was actually litigated, found compensable, and that the treatment claimant needs due to the surgery is compensable as well.

In the aggravation claim case, the issue before Referee Irving was whether claimant's worsened right knee condition and the treatment she required for that condition since the January 1990 claim closure claim, were compensable. The employer had denied the aggravation claim on October 19, 1989, on the asserted ground that the worsening and the medical treatment required since closure were not materially related to the 1988 compensable injury, but were instead, caused solely by the preexisting arthritis condition. (Ex. 15). At the hearing on the aggravation claim denial, there was no question but that claimant's condition had worsened and that a total right knee replacement was required. The only issue in dispute was whether the worsening and the attendant surgery were materially related to the 1988 compensable knee injury.

At the hearing on the aggravation claim denial, Referee Irving found the opinion of Dr. Neumann, claimant's treating physician, more persuasive than the opinion of the Drs. McHolick, Short and Lewis, recounted in the findings above. Accordingly, the Referee set aside the employer's denial and ordered the claim to be accepted and processed. Pursuant to that order, the employer paid for the November 1989 right knee replacement and the treatment given after that surgery until January 31, 1991. On that date, the employer denied claimant's "current condition." At that time, claimant's "current condition" obviously did not require a total knee replacement, for that procedure had already been done. Rather, the issue raised by the denial was the compensability of the treatment claimant required because of the surgery.

Thus, the question here is whether the post-operative treatment claimant received as necessary to recover from the effects of the compensable surgery may be denied by the insurer on the ground that the major contributing cause of the need for surgery was the preexisting arthritis condition. We think not.

Although the major contributing cause of claimant's need for a right knee replacement may well have been the preexisting arthritis condition, according to the evidence, claimant needs the treatment solely because of the surgery. As an integral part of the compensable surgical procedure, the treatment necessitated by the surgery is also compensable. Furthermore, the preexisting condition was essentially excised by the compensable surgical procedure. It is now the compensable surgery rather than the preexisting condition which necessitates the treatment in dispute. Accordingly, the employer's denial will be set aside.

Claimant is entitled to an assessed attorney fee for prevailing over the self-insured employer'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 is \$4,000, 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 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 January 15, 1992 is reversed in part and affirmed in part. That portion which upheld the self-insured employer's denial is reversed. The self-insured employer's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of \$4,000, payable by the self-insured employer. The remainder of the order is affirmed.

October 29, 1992

Cite as 44 Van Natta 2197 (1992)

In the Matter of the Compensation of
DEBRA L. COOKSEY, Claimant
WCB Case No. 91-12830
ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
VavRosky et al., Defense Attorneys

The self-insured employer requests reconsideration of our October 14, 1992 Order on Review which: (1) modified a Referee's order and awarded claimant 18 percent (57.6 degrees) unscheduled permanent disability for her low back condition in lieu of the Referee's award of 25 percent (80 degrees) unscheduled permanent disability; (2) reversed the Referee on the issue of rate of scheduled permanent disability; (3) affirmed the Referee's award of 5 percent (7.5 degrees) scheduled permanent disability for claimant's chronic condition limiting repetitive use of her right leg; and (4) awarded claimant an attorney fee for successfully defending against the insurer's request for a reduction of her scheduled permanent disability award.

On reconsideration, the employer contends that there is no authority for an attorney fee award because we reduced claimant's permanent disability award on review. The employer cites to Shoulders v. SAIE, 300 Or 606 (1986), in which the Supreme Court held that, even though two of claimant's conditions were found to be noncompensable, claimant was entitled to an attorney fee for prevailing on compensability of two other conditions as each condition must be considered separately. The Court held that, because compensation was not reduced in relation to two of claimant's conditions, claimant was entitled to an attorney fee pursuant to 656.382(2) for successfully defending against reduction of compensation for those conditions. Id. at 610.

On reconsideration, the employer contends that, in the present case there is only one condition (claimant's low back condition) and the issue is the extent of permanent disability for that condition.

The employer argues that we cannot award claimant an attorney fee just because it did not prevail on all of its challenges to the Referee's awards.

We disagree that our attorney fee award is inconsistent with the holding of Shoulders v. SAIF, supra. In Shoulders, the Court found that no attorney fee was available to claimant for two of his conditions because those conditions were found to be not compensable. Here, however, the employer has not argued that claimant's leg condition is not related to the compensable condition. In affirming the Referee's permanent disability award concerning claimant's leg condition, it necessarily follows that the record establishes that claimant's leg condition was caused by the compensable disc condition. Moreover, for purposes of rating disability, claimant's scheduled leg condition is treated separately from the unscheduled low back condition.

We find that when claimant's conditions have been considered separately for purposes of rating of permanent disability and the employer has presented separate and distinct arguments regarding each condition which claimant is required to defend, it is appropriate to award an attorney fee for the specific condition which was not reduced by an employer's appeal.

Accordingly, the employer's request for reconsideration is granted and our October 14, 1992 order withdrawn. As supplemented herein, we adhere to and republish our October 14, 1992 Order on Review. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

October 29, 1992

Cite as 44 Van Natta 2198 (1992)

In the Matter of the Compensation of
GARY D. GUNTER, JR., Claimant
 WCB Case No. 91-14428
 ORDER ON REVIEW
 Ronald A. Fontana, Claimant Attorney
 Charles Lundeen, Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of that portion of Referee Quillinan's order that upheld the insurer's denial of his aggravation claim for a low back condition. In his reply brief, claimant moves to strike those portions of the insurer's respondent's brief which refer to an Exhibit 24A. On review, the issues are motion to strike and aggravation. We grant the motion to strike and affirm on the merits.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Contending that Exhibit 24A was neither offered nor admitted into evidence, claimant moves to strike those portions of the insurer's respondent's brief which refer to this exhibit. From our reading of the insurer's brief, Exhibit 24A appears to concern a pre-closure medical examination. The record before us contains no Exhibit 24A. Nonetheless, we find that the record is completely developed. Accordingly, claimant's motion to strike is granted. We have reviewed the record de novo without considering the offensive portions of the insurer's brief.

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 uncheduled low back 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).

The Referee concluded that claimant successfully proved a symptomatic exacerbation of his condition but that he failed to establish that his symptomatic worsening exceeded anticipated waxing and waning. On review, claimant argues that no evidence in existence at closure predicted future waxing and waning of his condition. Therefore, claimant contends, the Referee incorrectly concluded that the last award of compensation contemplated such periods of waxing and waning.

The Referee based her conclusion, in part, on that fact that claimant experienced an acute symptomatic worsening shortly before his claim was closed. However, a history of past flare-ups alone is insufficient evidence on which to base a finding that a worsening was no more than a waxing and waning of symptoms contemplated by the previous award of permanent disability. Lucas v. Clark, supra. There must also be medical evidence predicting such flare-ups. Id.

We agree with claimant that the record here does not contain evidence of predicted future flare-ups, as opposed to the expectation of continuing symptoms of a chronic nature. Accordingly, we disagree with the Referee's conclusion that claimant's worsening constituted a waxing and waning of symptoms contemplated by the previous permanent disability award. Nevertheless, we agree with the Referee's conclusion that claimant has failed to establish a compensable aggravation.

We find that there is no persuasive evidence that claimant's symptomatic increase resulted in diminished earning capacity below the level fixed at the time of the last award of compensation. Claimant was not working at the time of the last award of compensation. Further, on May 6, 1991, Dr. Constien, claimant's treating physician, reported that as a result of daily pain, continued limited range of back motion and right leg weakness, claimant should be retrained for work in a sedentary occupation. (Ex. 21).

Subsequently, on June 24, 1991, claimant underwent a physical capacities evaluation by Western Medical Consultants, Inc., who reported a marked contrast between claimant's extreme pain behaviors during his examination as compared to a video tape recording of claimant's activities. Based on this contrast, the Consultants' examiner opined that the validity of the examination was "significantly [in] question." On July 10, 1991, Dr. Constien indicated that he concurred with that report. (Ex. 25).

Claimant's condition symptomatically worsened in August 1991 following a fracture of his left fifth metatarsal. Claimant was placed in an elevated leg splint.

Three months later, Dr. Constien reported claimant's comments that "my back is still killing me" and that he "feels just like it was when I first got hurt." Dr. Constien noted that claimant's splint was off and that claimant felt his foot was back to normal following his fracture. Dr. Constien concluded that claimant's "chronic pain symptoms are limiting in his ability to hold down a job of any more than a sedentary nature. (Ex. 31B).

Although earlier --on October 7, 1991-- Dr. Constien reported that claimant was unable to work (Ex. 30), this statement is unpersuasive in light of claimant's continuing reports of unabated symptoms and Dr. Constien's subsequent release to sedentary work despite those symptoms. Further, it is not clear from Dr. Constien's conclusory October 7, 1991 release-from-work statement whether claimant was then unable to work solely due to increased back symptoms or also due to the effects of his metatarsal fracture. This is particularly true in light of the fact that Dr. Constien released claimant from work retroactive to the date of his metatarsal fracture, whereas Dr. Constien's theory is that it was claimant's abnormal walking, due to the fracture and elevated splint, which caused claimant's worsened back symptoms. (Ex. 32). It thus appears that at least a portion Dr. Constien's work release was due to the fracture.

In sum, the only persuasive evidence is that claimant was able to perform sedentary work at the time of the last award of compensation and that he remained capable of performing such work during the period of his symptomatic worsening. Under the circumstances, we conclude that claimant has failed to establish that his earning capacity was diminished below the level fixed at the time of the last award of compensation. Accordingly, his claim for aggravation fails.

ORDER

The Referee's order dated January 16, 1992 is affirmed.

October 29, 1992

Cite as 44 Van Natta 2200 (1992)

In the Matter of the Compensation of
ROGER F. HAYDEN, Claimant
WCB Case No. 91-09168
ORDER ON REVIEW
Ainsworth, et al., Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Brown's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for bilateral shoulder, upper back and neck myofascial pain syndrome. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant experienced upper back and neck pain prior to his current employment. The diagnosis was chronic thoracocervical sprain and claimant received related chiropractic treatments on several occasions between May 1986 and July 1989. His symptoms often arose in the spring and early summer during those years, when claimant engaged in vigorous off-work bicycling.

Claimant's current work as a newspaper reporter for the employer involves repetitive keyboard work at a computer terminal. In addition, claimant often holds a telephone between his head and his shoulder, in order to speak and listen while simultaneously typing at work. His current problems began with a gradual onset of pain, after working for the insured for several months. He sought treatment from Dr. Dunn, neurologist, in December, 1990. After an off-work camera carrying incident in the spring of 1991, claimant's symptoms became severe and he sought treatment from a chiropractor and from Dr. Ewald, M.D. Ewald diagnosed myofascial syndrome and referred claimant to Dr. Grant, physiatrist, who provided treatment under the same diagnosis.

On May 1, 1991, claimant filed a claim for "soreness in his upper shoulders and back." (Ex. 6). On May 13, 1991, SAIF denied the claim. (Ex. 7).

ULTIMATE FINDINGS OF FACT

Claimant's work activities for SAIF's insured were the major cause of his current disability and need for treatment for upper back and neck myofascial pain syndrome.

The existence of claimant's occupational disease, upper body myofascial syndrome, is established by medical evidence supported by objective findings.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's claim for upper body myofascial pain syndrome is not compensable, primarily because he found Dr. Grant's opinion regarding causation to be unpersuasive. We disagree.

Claimant's work as a newspaper reporter for SAIF's insured involves repetitive keyboard work at a computer terminal. His work also often requires that he hold a telephone between his head and his shoulder to speak and listen, while simultaneously typing. Considering the repetitive and traumatic nature of these activities, we find that the claim is for a condition resulting from a "series of traumatic events or occurrences" under ORS 656.802(1)(c). Accordingly, to carry his burden 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."

In this case, it is undisputed that claimant had prior upper back and neck pain and that he sought related chiropractic treatment on several occasions between May 1986 and July 1989. As the Referee noted, claimant's prior symptoms often corresponded with his vigorous early summer bicycle riding. Claimant's prior diagnosis was chronic thoracocervical sprain.

Claimant's current problems began with a gradual onset of pain, after working for the insured for several months. He sought treatment from Dr. Dunn, neurologist, in December, 1990. (See Ex. 4). After an off-work camera carrying incident in the spring of 1991, claimant's symptoms became severe and he sought treatment from a chiropractor and from Dr. Ewald, M.D. Ewald reported the exacerbation of symptoms following the camera carrying incident. He also noted that claimant's "symptoms are increased by prolonged sitting at work over the computer terminal and by holding his head in right lateral flexion while writing and speaking on the phone at work." (Ex. 5). Ewald diagnosed myofascial syndrome and commented that claimant's history is compatible with a cumulative trauma from prolonged stationary posturing at work. (Id). Ewald doubted that claimant's off-work activities had an adverse effect on his symptoms, because those activities are not stationary. Rather, Ewald opined that the cumulative effect of claimant's posturing at work caused the myofascial syndrome. (Ex. 8a).

On May 1, 1991, claimant filed a claim for "soreness in his upper shoulders and back." (Ex. 6). On May 13, 1991, SAIF denied the claim. (Ex. 7).

Ewald referred claimant to Dr. Grant, M.D. Grant examined and treated claimant on three occasions. He agreed with Ewald that claimant's posturing at work caused the myofascial syndrome. Specifically, Grant described the cause as claimant's operating a computer terminal at work, often with a telephone receiver cradled on his hunched shoulder. (Ex. 10).

Grant apparently first learned of claimant's off-work sports activities and prior chiropractic treatments prior to 1990 during a January 3, 1992 deposition. (See Exs. 11-6-7 & 11-17-18). Considering this new information, but without knowing the prior chiropractor or reviewing his records, Grant was unable to say with certainty whether claimant's prior problems were myofascial in nature. However, based on the treatment pattern prior to 1990, Grant suspected that the earlier condition was a "garden variety" strain, rather than a myofascial condition. (See Ex. 11-27-28).

Even considering claimant's earlier symptoms and treatment, Grant was able to unequivocally conclude that claimant's current myofascial condition is work-related. He explained that vigorous physical activities are encouraged as therapeutic for myofascial patients, rather than suspected as causative. Claimant's work activities, particularly his posturing, on the other hand are directly implicated as causing his current problems. In this regard, Grant noted that claimant had no symptoms during a vacation week of camping, but his pain returned as soon as he was back on the job.

Moreover, even though a bicycle of the wrong size could trigger myofascial symptoms, Grant doubted that claimant's bicycling or other off-work activities caused his current condition. (See Ex. 11-7-8; 11-24; see also Ex. 8b). Grant explained that a myofascial condition, other than one related to a single traumatic incident, is caused by multiple repetitive traumas, over an extended period of time (See 11-8-9 & 11-10). In this respect, claimant's work activities are distinguished from his off-work activities, because, claimant clearly spends more time hunched over his keyboard, often with the telephone receiver cradled between his head and shoulder, than he does engaging in sports. In our view, Grant's clear, well-reasoned opinion, which evaluated claimant's history of record, is persuasive. Based on Grant's opinion, we further find that claimant's current work-related condition is distinguishable and distinct from his prior upper body problems.

By contrast, Medical Consultants Northwest, independent examiners, were "unable to state that the major contributing cause of [claimant's] symptoms is his work exposure[.]" (Ex. 8-5). Their doubt was based on claimant's history of strenuous off-work physical activity, including regular running and biking. However, inasmuch as Grant's opinion explains why work is the cause in this case and the Consultants do not refute Grant's reasoning, the Consultants' conclusions are not particularly persuasive.

Dr. Stanford, independent examiner and orthopedist, opined that claimant's current symptoms appear the same as those prior to this work exposure and concluded that the current problems are related to claimant's off-work activities, as the independent examiners believed they had been in the past. (Ex. 9). However, because Stanford does not address the likelihood that the current condition is not a continuation of earlier problems, as explained by Grant, Stanford's conclusions are likewise unpersuasive.

As we have stated, we find Grant's opinion in particular to be persuasive as it is well-reasoned and based on a complete history. See Somers v. SAIF, 77 Or App 259 (1986). Furthermore, because, we find no reason to discount the opinions of claimant's treating physicians, Grant and Ewald, we rely on them. See Weiland v. SAIF, 64 Or App 810 (1983). In addition, we find that claimant's occupational disease claim is established by medical evidence supported by objective findings, which include a trigger point identified by Grant. (See Ex. 11-2). Accordingly, we conclude that claimant has established that his work activities for SAIF's insured were the major contributing cause of his current disability and need for treatment for bilateral shoulder, upper back and neck myofascial pain syndrome. See ORS 656.802.

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 \$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 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 February 27, 1992 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to it for further processing in accordance with law. For his services at hearing and on review, claimant's counsel is awarded an attorney fee of \$4,000, payable by SAIF.

In the Matter of the Compensation of
JOAN M. HEPLER, Claimant
WCB Case No. 91-14298
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
James Booth (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of Referee Thye's order holding that claimant's right knee injury claim had been prematurely closed. On review, the issue is premature closure. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's right knee injury claim had been prematurely closed by a June 12, 1991 Determination Order. We agree.

ORS 656.268(1) provides that an injured worker's claim for compensation shall not be closed if the worker's condition has not become medically stationary. "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. Scheuning v. J. R. Simplot & Company, 84 Or App 622 (1987).

In this case, claimant's claim was closed by a June 21, 1991 Determination Order, which found her to be medically stationary as of April 29, 1991. The closure of the claim evidently was based on an April 29, 1991 report from Dr. James, the treating physician, in which he noted that claimant's knee condition had stabilized. However, on May 24, 1991, prior to claim closure, James reported that claimant had experienced an exacerbation of her right knee condition and recommended further treatment. On June 3, 1991, James further reported that he was unable to complete a functional capacity evaluation of claimant due to the flare-up and recommended against claim closure.

Based on that un rebutted evidence, we agree with the Referee that improvement in claimant's then existing knee condition was reasonably expected with medical treatment at that time. Accordingly, we conclude that the June 12, 1991 Determination Order must be set aside as premature. ORS 656.283(7).

SAIF first argues that claimant is precluded from asserting premature closure, because she failed to raise the issue in her request for mandatory reconsideration of the Determination Order. See ORS 656.268(5). There is no evidence on the record, however, that SAIF properly raised that issue before the Referee. Accordingly, we decline to address it on review. Stevenson v. Blue Cross, 108 Or App 247 (1991).

In reaching this decision, we reject SAIF's assertion that the issue involves subject matter jurisdiction and, therefore, can be raised at any time. Subject matter jurisdiction depends solely upon whether a decision-making body has the authority to make an inquiry. It exists when a statute authorizes that body to do something about the dispute. SAIF v. Roles, 111 Or App 597 (1992). In this case, the Referee clearly had the authority under ORS 656.283(1) to address the issue in dispute, regardless of whether claimant may have waived her right to litigate it.

SAIF next argues that the Referee improperly considered medical reports from Dr. James concerning the status of claimant's condition after April 29, 1991, the date it believes to be the date of closure. SAIF is correct that, in determining whether a claim was prematurely closed, we look to whether a claimant was medically stationary on the date of closure, without considering subsequent changes in her condition. Scheuning v. J. R. Simplot & Company, supra. SAIF is mistaken, however,

as to the date of closure, which, in this case, is June 21, 1991, the date of the Determination Order. See Austin v. SAIF, 48 Or App 7 (1980). The Referee did not err.

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 premature closure issue is \$850, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 11, 1992 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of \$850, to be paid by the SAIF Corporation.

October 29, 1992

Cite as 44 Van Natta 2204 (1992)

In the Matter of the Compensation of
KATHRYN C. KENNEDY, Claimant
 WCB Case No. 91-12141
 ORDER ON REVIEW
 Peter O. Hansen, Claimant Attorney
 Steve Cotton (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

The SAIF Corporation requests review of that portion of Referee Bethlahmy's order that found that the Hearings Division has jurisdiction over a dispute concerning the interpretation of a Stipulated Order. 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 parties seek resolution of a dispute involving compensability of footwear prescribed by claimant's treating physician. Finding that the issue before her involved the terms and enforcement of a Stipulated Order, the Referee concluded that the Hearings Division has jurisdiction over this matter. SAIF argues that the prescribed footwear is not compensable because the 1990 amendments in Oregon Laws 1990 (Special Session), chapter 2, designate that the Director, rather than the Hearings Division, decides what are reasonable and necessary medical services. Thus, SAIF contends, the 1990 Laws have removed this issue from the jurisdiction of the Hearings Division. We agree.

We have held that, when a dispute solely concerns the meaning and appropriate application of the Stipulated Order's terms, the Hearings Division has jurisdiction to enforce the stipulation. Patrick E. Riley, 44 Van Natta 281 (1992), aff'd mem Pendleton Woolen Mills v. Riley, 115 Or App 758 (1992). However, where the stipulation terms are such as to invoke the Director's jurisdiction, claimant cannot invoke the jurisdiction of the Hearings Division before seeking administrative review by the Director. See B.D. Schlepp, 44 Van Natta 1637 (1992); Riley, supra; Kevin A. Haines, 43 Van Natta 1041 (1991).

In the present case, the June 9, 1988 stipulated order provides that SAIF "agrees to pay for shoes which are provided for medical purposes, as long as they are medically reasonable and necessary." Unlike the Stipulated Orders in Schlepp, supra, and Haines, supra, the stipulation makes no reference

to any statute or administrative rule. However, we do not find the absence of an express reference to a statute or rule to be dispositive of the jurisdictional issue.

In Schlepp, the parties' stipulation provided that the "claimant's treatment * * * is allowed under ORS 656.245 provided the treatment remains reasonable and necessary, as related to the industrial injury." Therefore, we reasoned, the reasonableness and necessity of the palliative treatment must be determined in order to enforce the stipulation. We concluded that a dispute over palliative care that is allegedly not reasonable and/or necessary is in the exclusive province of the Director under the new law. Although we noted that the stipulation expressly referenced ORS 656.245, it is apparent that our decision regarding jurisdiction was based primarily on the nature of the parties' dispute, *i.e.*, whether the treatment at issue was reasonable and necessary.

Here, as in Schlepp, the dispute for which the parties seek resolution is the reasonableness and necessity of the prescribed footwear. Under the new law, resolution of that dispute rests exclusively with the Director. Stanley Meyers, 43 Van Natta 2643 (1991). Therefore, we conclude that neither the Hearings Division nor the Board has jurisdiction to determine this matter.

ORDER

The Referee's order dated January 6, 1992 is vacated. Claimant's request for hearing is dismissed.

October 29, 1992

Cite as 44 Van Natta 2205 (1992)

In the Matter of the Compensation of
STEPHEN SCHAFF, Claimant
WCB Case No. 91-09431
ORDER ON REVIEW (REMANDING)
Burt, Swanson, et al., Claimant Attorneys
Cooney, Moscato, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Davis' order that affirmed an Order on Reconsideration award of 8 percent (25.6 degrees) unscheduled permanent partial disability for loss of hearing in his right ear. On review, the issue is extent of unscheduled permanent disability. We remand.

FINDINGS OF FACT

Claimant sustained a compensable injury in October 1988, when he was thrown from his vehicle while delivering pizzas. He began treating with Dr. Buza, who diagnosed multiple injuries including a basal skull fracture with an epidural hematoma and hearing loss in the right ear. Following a period of treatment, Buza released claimant to regular work without restrictions in January 1989.

In October 1989, claimant changed his attending physician to Dr. Siegfried, a chiropractor, for treatment for back pain and other symptoms related to his compensable injury. In June 1990, Siegfried became ineligible to be an attending physician under the Workers' Compensation Law.

In September 1990, claimant was examined by Dr. Friedman for a neurophysical evaluation. Friedman found claimant medically stationary with very mild impairment from the head injury. The insurer asked Buza to comment on Friedman's assessment, but Buza declined since he had not seen claimant since June 1989.

Claimant's claim was closed by a November 14, 1990 Determination Order that awarded claimant benefits for period of temporary disability and 8 percent unscheduled permanent partial disability for loss of hearing in the right ear. An April 18, 1990 Order on Reconsideration affirmed the Determination Order in its entirety. Claimant requested a hearing.

CONCLUSIONS OF LAW AND REASONING

Claimant seeks review of the Referee's order that affirmed an Order on Reconsideration award of 8 percent unscheduled permanent partial disability. Claimant argues that the medical evidence is insufficient to determine the extent of his permanent impairment, because his attending physician, Dr. Buza, did not perform a closing examination or make findings regarding the permanent residuals of his head injury.

After our review, we adopt the Referee's reopening and conclusion that Dr. Buza was not claimant's attending physician at the time of closure. Even if we assume that he was, however, it is claimant's responsibility under ORS 656.266 to establish the extent and nature of any permanent disability. Here, Dr. Buza declined to offer an opinion concerning the extent of impairment. Under these circumstances, the fact that the record contains no findings from an attending physician regarding claimant's impairment would speak to a failure of proof on the part of claimant, not an invalid Order on Reconsideration. See John M. Ames, 44 Van Natta 684 (1992).

Nonetheless, an Order on Reconsideration is invalid where the request for reconsideration challenges the impairment findings used in the rating of disability and the Director fails to appoint a medical arbiter as required by ORS 656.268(7). See Olga I. Soto, 44 Van Natta 697 (1992) recon den 44 Van Natta 1609 (1992). In this case, claimant appears to challenge the (lack of) medical findings of impairment, but his request for reconsideration is not in the record. Because the basis of his request is unknown, we are unable to determine whether the Director should have appointed a medical arbiter as part of the mandatory reconsideration process and, consequently, whether the Order on Reconsideration is valid for review. See Peter L. Galiano, 44 Van Natta 1197 (1992). Under these circumstances, we conclude that the record is improperly, incompletely or otherwise insufficiently developed and find it appropriate to remand this matter to the Referee for further proceedings consistent with this order. See 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 March 20, 1992 is vacated. The matter is remanded to Referee Davis for further proceedings consistent with this order.

In the Matter of the Compensation of
HEATHER I. SMITH, Claimant
WCB Case No. 91-05062
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The self-insured employer requests review of those portions of Referee Lipton's order that: (1) awarded 13 percent (41.6 degrees) unscheduled permanent partial disability for a bilateral neck, right shoulder and left arm condition, whereas a Determination Order had awarded no unscheduled permanent disability; and (2) directed it to pay claimant's 5 percent (7.5 degrees) scheduled permanent disability awarded by the Determination Order at the rate of \$305 per degree. On review, the issues are extent of unscheduled permanent 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

Unscheduled permanent disability

As the Referee found, the November 8, 1990 Determination Order declared claimant medically stationary as of September 5, 1990 and awarded 5 percent scheduled permanent disability for claimant's right forearm. (Ex. 25). In compliance with ORS 656.268(5), claimant first sought reconsideration of the order from the department, contending that she was entitled to unscheduled disability. (Ex. 26-1). On April 15, 1991, the Appellate Unit affirmed the order. (Ex. 33-1). Claimant then sought review of the reconsideration order. See ORS 656.268(6)(b).

The Referee awarded 13 percent unscheduled permanent disability, based in part on finding an impairment value of 5 percent for a chronic condition limiting repetitive use and an adaptability value of 8. The employer objects to both findings, contending that the impairment value relates only to a scheduled body part and that the adaptability value does not reflect the fact that claimant now works part-time in a sedentary to light capacity.

Turning first to the impairment issue, the medical evidence regarding impairment includes a physical capacities evaluation completed by the Work Center for Ergonomics on May 24, 1990, several months before claimant's medically stationary date. On November 29, 1990, claimant's treating physician, Dr. Kemple, internist, referred to the evaluation with approval, therefore providing proof that Kemple regarded the evaluation as accurately reporting the status of claimant's condition as of that date. Therefore, unlike the Referee, we take into consideration the evaluation in determining permanent disability.

The evaluation noted that claimant experienced pain in the "right neck, shoulder, elbow and wrist associated with sustained or repetitive" activities and stated that claimant "should perform minimal reaching, either forward or overhead" and recommended that she "avoid forceful use of the upper extremities, especially on the right." (Ex. 17-2). Kemple reported that claimant continued to exhibit "a clear pattern of aggravation with any substantial arm use and she is limited in her capacity for housekeeping chores, particularly any prolonged work such as cleaning, vacuuming and particularly in relation to overhead work." (Ex. 16-5).

The remaining evidence includes a report from Dr. Phipps, neurologist, and Dr. Fraback, internist, both of whom conducted independent medical examinations. Phipps found no "rateable impairment" (Exs. 21-3, 28), but stated that "other jobs that do not require repetitive use of the hands would be best." (Ex. 21-3). Dr. Fraback reported that claimant's permanent impairment "would be some limited motion in her right wrist." (Ex. 30-4).

The employer is correct that much of the evidence refers to a chronic condition limiting repetitive use of claimant's right wrist, a scheduled body part, and that claimant has received permanent scheduled disability for such impairment. Relying on Kemple's opinion, however, as well as the physical capacities evaluation of which he approved, we also find that the evidence demonstrates that claimant suffers a chronic condition limiting repetitive use of her shoulder, an unscheduled body part. Therefore, we conclude that claimant is entitled to a rating of 5 percent impairment under former OAR 436-35-320(5).

We next address the employer's contention that claimant is not entitled to an adaptability value of 8. Review here is of the April 15, 1991 Reconsideration Order that was issued under ORS 656.268. As of that date, claimant was working part-time in a sedentary to light capacity. The employer asserts, therefore, that claimant's adaptability should be rated under former OAR 436-35-310(3). Claimant contends, however, that because claimant was not working as of the date of the Determination Order, claimant's adaptability should be rated in accordance with former OAR 436-35-310(4).

We previously addressed this issue in Vickie M. Libel, 44 Van Natta 294, on recon 44 Van Natta 413 (1992), concluding that adaptability should be rated at the "time of determination." We based our conclusion on former OAR 436-35-310(1)(a), which states that the impact for the factor of adaptability "is based upon the worker's work status at and before the time of determination[.]" "Time of determination" is the mailing date of the Determination Order or Notice of Closure. Former OAR 436-35-005(8).

We acknowledge that ORS 656.283(7) provides that the referee shall evaluate claimant's disability as of the date of issuance of the reconsideration order pursuant to ORS 656.268. However, we do not conclude from this language that changes in claimant's work status which occur between the date of closure and the reconsideration order should be taken into account in determining claimant's adaptability. We note in this regard that, as originally drafted by the Governor's Interim Special Committee on Workers' Compensation, ORS 656.283(7) provided that evaluation of the worker's disability shall be as of the date of issuance of the notice of closure or the determination order. In response, the Department of Insurance and Finance provided written testimony to the Committee pointing out that, as drafted, ORS 656.283(7) would not permit consideration of the medical arbiter's report provided for by ORS 656.268(7). The statute was subsequently changed to its present reading. Based on this history, we conclude that the intent of ORS 656.283(7) was to permit consideration of a medical arbiter's report during the reconsideration proceeding, not to allow one party to establish that one of the factors involved in determining disability had changed since the claim was closed.

We find further support for this conclusion in the language of ORS 656.268(5) which limits the evidence which may be submitted at the reconsideration proceeding. That statute provides for the submission by the parties of evidence that corrects information in the record that is erroneous or that should have been but was not submitted by the worker's attending physician at the time of claim closure. The statute does not provide for the submission of additional evidence of subsequent changes in claimant's condition either in terms of the social/vocational factors or permanent impairment. See Grace M. Nyburg, 44 Van Natta 1875 (1992)(worsened condition occurring between date of closure and date of reconsideration order treated as aggravation): We would reject an interpretation that, for example, would permit a change in claimant's age between the date of closure and the date of the reconsideration order to affect claimant's permanent disability rating.

Accordingly, we conclude that the Director's rules which provide that claimant's adaptability is to be determined as of the date of issuance of the notice of closure or determination order are consistent with the statute. Therefore, we reaffirm our decision in Vickie M. Libel, supra, and we rate claimant's adaptability according to claimant's work status at and before the mailing date of the Determination Order.

The record establishes that claimant was not working as of the mailing date of the November 8, 1990 Determination Order. Therefore, adaptability is rated under former OAR 436-35-310(4), which provides that "the factor of adaptability is based upon the worker's residual physical capacity." We agree with the Referee that claimant's work status at and before the time of determination falls under the light to sedentary category with restrictions. (See Ex. 17-1). Claimant thus is entitled to an adaptability factor of 8.

Therefore, having found that the Referee correctly found that claimant was entitled to 5 percent impairment for a chronic condition and an adaptability factor of 8, we conclude the Referee properly awarded claimant 13 percent unscheduled permanent partial disability.

Scheduled disability

The employer also contests the Referee's conclusion that claimant's scheduled disability award should be paid at \$305 per degree because the award was made after May 7, 1990. 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).

Here, 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).

Finally, because the employer requested review, and the Board did not disallow or reduce claimant's unscheduled permanent disability award, claimant's counsel is entitled to an assessed fee under 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 concerning the unscheduled permanent disability issue is \$600, 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 26, 1991 is affirmed in part and reversed in part. Those portions 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 and granted an out-of-compensation attorney fee from this increased compensation are reversed. The remainder of the order is affirmed. For services on Board review concerning the extent of unscheduled permanent disability issue, claimant's counsel is awarded an assessed fee of \$600, to be paid by the insurer.

In the Matter of the Compensation of
SHERRY L. WATSON, Claimant
WCB Case No. 91-09976
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Gruber's order that: (1) upheld the SAIF Corporation's denial of claimant's occupational disease claim for left shoulder and left arm conditions; and (2) declined to award a penalty and attorney fee for an allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the first three paragraphs, which we replace with the following:

Claimant, since March 1990, has worked for the employer as a city bus driver. In June 1978, she sustained a left wrist strain. (Exs. 1, 2). In November 1981, claimant underwent left carpal tunnel release surgery. (Ex. 3). In January 1984, claimant underwent right carpal tunnel release surgery. (Ex. 4).

In August 1980, claimant injured her left shoulder while throwing brush and received two injections for inflammation. (Tr. 7-8). In October 1987, claimant injured her left elbow. (Ex. 5, Tr. 8).

In September 1985, claimant received chiropractic treatment to her mid-back. (Tr. 30). In September 1986, claimant received chiropractic treatment to her neck, upper back, and lower back. (Tr. 31).

CONCLUSIONS OF LAW AND OPINION

Compensability

The Referee concluded that claimant had failed to prove the compensability of her left shoulder and arm conditions. See ORS 656.802(2). The Referee based this conclusion on his finding that an independent medical examination report contained the more persuasive evidence regarding the cause of claimant's symptoms. Claimant disputes this conclusion, asserting that the report is not reliable and that, through the report of Dr. Goins, neurologist, her treating physician, and Dr. Kuller, M.D., she proved compensability.

The record contains three reports regarding causation. Drs. Barth, neurologist, and Baker, orthopedist, diagnosed a "left shoulder girdle strain by history, recurrent." (Ex. 20-6). The report found that claimant's "condition is not the natural progression of a pre-existing disease process but rather an example of waxing and waning of symptoms from a pre-existing left shoulder girdle strain dating back to 1980, with multiple treatments and multiple aggravations of this condition over the last eleven years." (Id.) The report concluded that claimant's "work as a bus driver is not the major contributing factor in the development of this current condition." (Id.) The report also found that it was possible that "work as a massage therapist, particularly in a training program, could exert a strain on the left shoulder girdle[.]" (Id.)

The report recited a history of several injuries to claimant's left shoulder and arm, including the 1980 shoulder injury and 1987 left elbow injury, as well as a 1985 thoracic strain from lifting a tool box, which resulted in chiropractic treatment to her left medial scapular area. (Id. at 2). The report also stated that claimant sought chiropractic care in September 1986 for massage to the "left upper trapezius muscle" and in May 1988 for left shoulder pain. (Id.)

In the Matter of the Compensation of
OMER L. OYSTER, Claimant
WCB Case No. 91-05452
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Black's order that upheld the self-insured employer's denial of his aggravation claim for a low back condition. In its brief, the employer contends that the Referee should have upheld its denial insofar as it denied claimant's current condition and need for treatment. On review, the issues are compensability of claimant's current condition and aggravation.

As a preliminary matter, we note that we may address any issue considered by the Referee, even in the absence of a cross-request for review on that issue. Destael v. Nicolai Company, 80 Or App 596, 600-01 (1986); William E. Wood, 40 Van Natta 999, 1001 (1988). Here, the issue of whether claimant's current condition is compensably related to the accepted injury was litigated by the parties and considered by the Referee. Therefore, even though the employer did not file a cross-request for review concerning the current condition issue, we may consider that issue on review. However, inasmuch as the employer did not file a cross-request for review, it is not entitled to submit a cross-reply brief on review. See OAR 438-11-020(2); 438-11-025. Accordingly, we reject the employer's reply brief and decline to consider it on review.

On the merits, we affirm and adopt the Referee's order with regard to both compensability of claimant's current condition and claimant's aggravation claim.

For successfully defending against the employer's challenge regarding compensability of his current condition, 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 current condition issue is \$800, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's cross-respondent's brief and statement of services), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for services rendered on review concerning his unsuccessful appeal of the aggravation issue.

ORDER

The Referee's order dated November 4, 1991 is affirmed. For services on Board review, claimant's counsel is entitled to an assessed fee in the amount of \$800, to be paid by the self-insured employer.

In the Matter of the Compensation of
CANDIS A. WADE, Claimant
WCB Case Nos. 91-07415 & 91-07414
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Nichols' order that: (1) set aside its "back-up" denial of claimant's occupational claim for a right forearm condition; (2) set aside its denial of claimant's occupational claim for a left wrist condition; and (3) awarded claimant's attorney \$2,800 at hearing. On review, the issues are compensability and attorney fees.

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

On review, the insurer makes several arguments asserting that it satisfied its burden for upholding the "back-up" denial for claimant's right forearm condition and that claimant failed to prove compensability of her claim for her left wrist condition. First, the insurer contends that claimant did not satisfy ORS 656.266, which provides that compensability is not proved "merely by disproving other possible explanations of how the injury or disease occurred." The insurer bases this assertion on the statements of Dr. Jones, claimant's treating physician, that the diagnosis of industrial overuse is "a diagnosis of exclusion," (Ex. 50-19), and that it is made "by excluding other possible conditions," (*id.* at 20). Although Dr. Jones did make these statements, he further stated that his diagnosis was also based on "serial examination" and claimant's history. (*id.* at 19). Therefore, we conclude that the diagnosis is supported by more than an exclusion of other possible causes of claimant's condition and that claimant satisfied ORS 656.266.

The insurer further asserts that claimant is not credible. Specifically, the insurer contends that the fact that claimant sold jewelry to the Marriott Corporation under a business name contradicts her statements to Dr. Jones and Dr. Nathan; that she made jewelry as a hobby. We find that the evidence preponderates in favor of the conclusion that claimant made jewelry as a hobby. Therefore, we find no basis for concluding that claimant was not credible.

Finally, the insurer contends that Dr. Jones' opinion was not supported by objective findings. The insurer's argument principally relies on Dr. Jones' statement that his diagnosis was not based on objective tests. (Ex. 50-20). A physician's diagnosis is supported by objective findings if it is based on purely objective factors or on the worker's description of the pain that he is experiencing, as long as the physician indicates that the worker in fact experiences symptoms and does not merely recite the worker's complaints of pain. Georgia Pacific Corporation v. Ferrer, 114 Or App 471 (1992); Suzanne Robertson, 43 Van Natta 1505 (1991). Although Dr. Jones' opinion did not rely on objective testing, his diagnosis clearly indicated that claimant actually experienced her reported symptoms. Therefore, we also reject the insurer's argument regarding objective findings.

Claimant is entitled to a reasonable attorney fee for prevailing against the insurer's request for review concerning the compensability issue. 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 \$1,000, 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 March 13, 1992, 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 of
DENNIS R. ADAMS, Claimant
WCB Case No. 92-04664
ORDER OF DISMISSAL
Ainsworth, et al., Claimant Attorneys
David O. Horne, Defense Attorney

The insurer has requested review of Referee Nichols' order dated July 13, 1992. Claimant has moved for dismissal, contending that the request is untimely. The motion is granted.

FINDINGS OF FACT

The Referee's order issued July 13, 1992. On August 17, 1992, the Board received the employer's request for review. The request, which was dated August 14, 1992, included the insurer's attorney's certificate of service by mail. The certificate stated that the request for review had been mailed to the Board on August 14, 1992 and that copies of the request had been mailed to the other parties on August 14, 1992.

On August 18, 1992, the Board mailed a computer-generated letter to the parties acknowledging the request.

CONCLUSIONS OF LAW

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

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

Here, the 30th day after the Referee's July 13, 1992 order was August 12, 1992. The insurer's request for review was not filed with the Board until August 17, 1992, the date the request was received by the Board. See ORS 656.289(3); 656.295(2); OAR 438-05-046(1)(b). The insurer's attorney's certificate of service does state that the request for review was mailed to the Board on August 14, 1992. Nevertheless, even if we found that the certificate established that the request was filed on August 14, 1992, the request would still be untimely filed.

Consequently, we lack jurisdiction to review the Referee's order. See ORS 656.289(3); 656.295(2); Argonaut Insurance Co. v. King, supra. Accordingly, the request for Board review is dismissed.

Finally, claimant seeks an attorney fee for services on review. However, when a request for Board review is dismissed without a decision on the merits, we are without authority to award attorney fees under ORS 656.382(2). Terlouw v. Jesuit Seminary, 101 Or App 493 (1990); Liberty Northwest Ins. Corp. v. McKellips, 100 Or App 549, 550 (1990). Therefore, claimant's request for an attorney fee is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
SHARON E. MILLER, Claimant
WCB Case No. 91-10773
ORDER OF DISMISSAL
Starr & Vinson, Claimant Attorneys
Wallace & Klor, Defense Attorneys
Cummins, et al., Defense Attorneys
Debra Ehrman (Saif), Defense Attorney

On September 10, 1992, the Board acknowledged by means of a computer-generated letter a request for review in this case. Firemans' Fund Insurance Company has moved for dismissal of the request, noting that claimant withdrew her request for hearing in this case. We grant the motion.

Claimant requested a hearing concerning the SAIF Corporation (WCB Case Nos. 91-01910 & 91-16090) and Firemans' Fund (WCB Case No. 91-10773). At the hearing, claimant withdrew her hearing request insofar as it pertained to Firemans' Fund. On May 12, 1992, the Referee issued an Order of Dismissal, dismissing claimant's hearing request concerning Firemans' Fund. (WCB Case No. 91-10773).

On August 31, 1992, the Referee issued an Opinion and Order concerning claimant's hearing requests with SAIF. (WCB Case Nos. 91-01910 & 91-16090). On September 8, 1992, the Board received claimant's request for Board review of the Referee's August 31, 1992 order.

On September 10, 1992, the Board mailed a computer-generated letter acknowledging a request for review in the two WCB case numbers which coincided with the Referee's August 31, 1992 order. In addition, the Board erroneously acknowledged the request for review as an appeal of the Referee's May 12, 1992 dismissal order.

Under such circumstances, we conclude that claimant did not request review of the Referee's May 12, 1992 order. (WCB Case No. 91-10773). Moreover, that order has become final by operation of law. ORS 656.289(3). Accordingly, review of this case is dismissed. Review of claimant's appeal of the Referee's August 31, 1992 order shall proceed in accordance with the previously implemented briefing schedule except that Firemans' Fund shall no longer be considered as a party to that proceeding.

IT IS SO ORDERED.

October 30, 1992

Cite as 44 Van Natta 2216 (1992)

In the Matter of the Compensation of
ROBERT C. CAYTON, Claimant
WCB Case No. 91-10622
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Kinsley, Brazeau and Hooton.

The SAIF Corporation requests review of Referee Livesley's order that awarded additional temporary disability. On review, the issue is temporary disability. We affirm in part, modify in part and reverse in part.

FINDINGS OF FACT

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

When claimant returned to modified work, his wages were the same or greater than at the time of injury. (Tr. 10).

CONCLUSIONS OF LAW AND OPINION

Temporary Disability Compensation

We adopt that portion of the Referee's opinion under the heading "applicable law," with the exception of the last sentence, and supplement as follows. A worker is entitled to an award for temporary disability for all periods in which a claim remains open and the attending physician has authorized benefits for temporary disability. OAR 436-30-036(1). We conclude that claimant was entitled to an award for temporary partial disability until his benefits were terminated according to law. OAR 436-60-030(4).

However, the analysis does not end there. If a worker is receiving at least his or her regular wage for modified work, he is entitled to benefits for temporary partial disability compensation at a rate of zero, both while employed and thereafter until termination of benefits is allowed. Safeway v. Owsley, 91 Or App 475 (1988). When claimant returned to modified work, his wages were the same or greater than at the time of injury. Thus, although claimant's return to school did not disqualify him from an award of temporary disability benefits, he is entitled to an award of temporary partial disability equal to zero.

Penalties and Attorney Fees

The next step in our inquiry is whether SAIF correctly terminated claimant's temporary partial disability benefit payments. As previously noted, where, as here, post-injury wages are the same or more than the wages earned at the time of injury, temporary disability benefit payments are equal to zero. OAR 436-60-030(2). Thus, SAIF was not liable for payment for temporary partial disability. Accordingly, no penalty or attorney fee is appropriate under either ORS 656.262(10) or 656.382(1).

ORDER

The Referee's order dated December 5, 1991 is affirmed in part, modified in part and reversed in part. That portion of the order which awarded penalties and attorney fees is reversed. That portion of the July 5, 1991 Order on Reconsideration which set aside claimant's entitlement to benefits for temporary partial disability is modified in accordance with our order. The temporary partial disability benefit amount is zero. The remainder of the order is affirmed.

Board Member Hooton dissenting.

The Referee analyzed this case by deciding that claimant did not voluntarily withdraw from the labor force. While it is clear that claimant had established a pattern of employment while continuing his status as a full-time student, and, therefore, did not withdraw from the labor force, that question alone does not establish claimant's entitlement to temporary disability compensation.

Without making additional findings of fact, the majority attempts to complete the Referee's analysis by examining whether claimant left work for reasons unrelated to his injury. Clearly, claimant left work to return to the university as a full-time student on a wrestling scholarship. Claimant's desire to return to school is unrelated to his injury. The majority, therefore, concludes that claimant left work for reasons unrelated to his injury and applies the rule outlined in Safeway v. Owsley, 91 Or App 475 (1988), to conclude that claimant continues to be entitled to temporary disability compensation but that the amount of that compensation is zero. Again, the resolution of the question whether claimant left work for reasons unrelated to his injury is not sufficient to fully analyze the present claim.

While I acknowledge that claimant testified that he terminated his employment with the employer to return to school on a wrestling scholarship, I am unable to conclude that the question ends there. Claimant also testified that, as the school year approached, he inquired of Al Fiedler whether there would be part-time work available for him during the school year. Consequently, the question I must resolve is whether the employer has a duty to provide part-time employment upon request by claimant.

This employer hired claimant in a part-time capacity in March of 1990, during the school year, and with full knowledge of his student status. Claimant testified that he worked full-time during the

summer and that there was an understanding that he would be able to continue part-time employment with the resumption of studies in September. Claimant further testified that he spoke with Mr. Fiedler, after his injury but prior to his return to school, regarding the availability of part-time employment when the school year began again. Claimant testified that Mr. Fiedler's response led him to conclude that employer would not make part-time work available. Consequently, employer was not only aware of claimant's student status but was also aware of his desire to continue part-time employment with employer.

The majority adopts the findings of fact of the Referee, as do I. Those findings include a findings that claimant is credible based on demeanor and manner of testimony. No credibility findings are made, affecting the employer witnesses. Because I rely upon the Referee's specific finding that claimant is a credible witness, and because the testimony of claimant and of employer witnesses are in direct conflict I would find, based upon contradictory credible evidence that Denise Jarvis is not a credible witness on behalf of employer, and that Al Fiedler's recollection of a discussion between himself and claimant regarding the availability of part-time work during the school year is faulty.

It would be inappropriate for us to require claimant to continue full-time employment and abandon the wrestling scholarship that will provide him with a college education, merely to maintain his eligibility for compensation benefits. In this situation, and absent any legislative action to the contrary, policy considerations favor supporting claimant's return to full-time student status. Consequently, I would require employer to make available part-time work in a modified capacity. The employer's failure to do so must be considered a withdrawal of the employer's modified employment offer. See, e.g., Shirley J. Sanderson, 44 Van Natta 484 (1992); Kati A. Hanks, 44 Van Natta 881, 882 (1992).

I acknowledge that Ms. Jarvis indicated that she would have continued claimant in a light duty part-time position if claimant had requested that she do so. However, I also note that Ms. Jarvis indicated that Mr. Fiedler remained claimant's supervisor following his return to work. Therefore, it was not inappropriate for claimant to address his desire for part-time employment to Mr. Fiedler rather than Ms. Jarvis. It is sufficient that the employer had knowledge of claimant's desire to maintain part-time employment. Claimant is not required to pursue that employment with the employer at injury beyond his initial inquiry to his post-injury supervisor.

I would find that the employer, in failing to provide part-time employment, consistent with claimant's limitations, following claimant's return to school in September of 1990, effectively withdrew its offer of modified employment. Consequently I would find claimant entitled to temporary partial disability benefits from September 14, 1990 through his medically stationary date. Because the majority does not consider whether the employer knew of claimant's desire to continue in part-time employment, and whether employer made an offer of employment consistent with claimant's injury limitations and his history as a full-time student, I must dissent.

October 30, 1992

Cite as 44 Van Natta 2218 (1992)

In the Matter of the Compensation of
ED D. CRABTREE, Claimant
WCB Case No. 91-00922
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Brazeau and Kinsley.

The self-insured employer requests review of Referee Michael V. Johnson's order that set aside its denial of claimant's back injury claim. On review, the issue is compensability.

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

The employer challenges the Referee's finding that claimant established a compensable back injury claim with medical evidence supported by objective findings. ORS 656.005(7)(a) requires that a

compensable injury be "established by medical evidence supported by objective findings." In order to carry this burden, claimant must offer evidence that a physician has examined him and determined that he suffers from a disability or a physical condition that requires medical services. See Georgia-Pacific Corporation v. Ferrer, 114 Or App 471 (1992); Suzanne Robertson, 43 Van Natta 1505 (1991). That determination may be based on purely objective factors, or on the worker's description of the pain that he is experiencing, so long as the physician indicates that the worker, in fact, experiences symptoms and does not merely recite the worker's complaints of pain. See ORS 656.005(19); Todd N. Hellman, 44 Van Natta 1082 (1992); Suzanne Robertson, *supra*.

Here, following the incident at work, claimant went to the emergency room complaining of pain and numbness in the low back and right leg. Dr. Driver performed a neurological examination. During the exam, claimant complained of increased pain while attempting to plantar flex the right foot. Dr. Driver prescribed pain medication and restricted him to light duty. (Ex. 2). Dr. Driver also ordered an MRI scan, but the study could not be completed because claimant complained of such severe back pain that he had to be removed from the scanner. (Ex. 3A). Claimant returned to Dr. Driver and was prescribed more pain medication. (Ex. 4).

Later, Dr. Driver concurred with a letter written by the employer's attorney, which stated that claimant had numerous subjective complaints but no "objectively verifiable" evidence of his injury. (Ex. 20). Based on this letter, the employer argues that Dr. Driver's reports do not provide objective findings of claimant's injury, as required by ORS 656.005(7)(a). We disagree.

As we held in Robertson and Hellman, claimant is not required to offer purely "objective" evidence to support his claim. The evidence may be subjective, so long as the physician determines that the condition actually exists. Dr. Driver's initial reports describe claimant's complaints of pain following the work incident. Although the complaints are subjective in nature, Dr. Driver's prescription for pain medication and light-duty restriction indicate that he believed claimant was, in fact, symptomatic and required medical treatment. That is sufficient medical evidence supported by objective findings. See *id.* We do not find that Dr. Driver's subsequent letter to counsel was intended to reverse his prior affirmation of claimant's 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 concerning the compensability issue is \$750, 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 April 10, 1992 is affirmed. Claimant's attorney is awarded \$750 for services on Board review, to be paid by the self-insured employer.

October 30, 1992

Cite as 44 Van Natta 2219 (1992)

In the Matter of the Compensation of
CYNTHIA M. GROSSMAN, Claimant
WCB Case No. 91-13105
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Brazeau and Kinsley.

Claimant, *pro se*, requests review of Referee Howell's order which upheld the insurer's partial denial of the following conditions: right deltoid tendonitis and inhalation restriction of the right upper three ribs with secondary sympathetic nervous system dysfunction in the hands. Claimant requests a new hearing in order to complete her testimony, which she asserts was cut short by a power failure.

On review, the issues are motion to remand and compensability. We deny the motion to remand and affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Remand

In her appellant's brief, claimant requests a new hearing on the grounds that she had insufficient time to testify because of a power failure affecting the hearing room during her testimony. We treat claimant's request as a motion to remand for additional evidence.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Olson, 37 Van Natta 1054, 1055 (1986), aff'd mem, 80 Or App 152 (1986).

Here, claimant's attorney concluded his direct examination of claimant by advising the Referee, "I don't have any other questions. Thank you." (Tr. 66). Counsel for the insurer declined cross-examination of claimant, and the Referee closed the hearing. (Tr. 66). In his order, the Referee explained that after the power failure, both parties waived further examination of witnesses and rested their cases. (O & O at 1).

Under these circumstances, we do not find that the record was "improperly, incompletely or otherwise insufficiently developed." Moreover, the attorney's failure to produce evidence, which is otherwise available and obtainable with due diligence, is not grounds for remand. See Diane E. Sullivan, 43 Van Natta 2791 (1991); Kirk D. Myers, 42 Van Natta 2757 (1990). Here, despite a power failure, claimant had the opportunity, through her attorney, to present additional testimony at the hearing, but declined to do so. For these reasons, claimant's motion to remand is denied.

Compensability

We adopt the Referee's order upholding the insurer's partial denial.

ORDER

The Referee's order dated February 21, 1992 is affirmed.

October 30, 1992

Cite as 44 Van Natta 2220 (1992)

In the Matter of the Compensation of
DAVID T. HANER, Claimant
 WCB Case No. 91-03404
 ORDER OF ABATEMENT
 Popick & Merkel, Claimant Attorneys
 Beers, et al., Defense Attorneys
 D. Kevin Carlson, Assistant Attorney General

The insurer requests reconsideration of our October 15, 1992 Order on Review, which vacated the Referee's order and remanded for further proceedings. The insurer has raised numerous matters for clarification.

In order to allow sufficient time to consider the motion, the above noted Board is withdrawn and claimant is requested to file a response to the motion within ten days. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

October 30, 1992

Cite as 44 Van Natta 2221 (1992)

In the Matter of the Compensation of
DAVID P. HARPER, Claimant
WCB Case No. 91-06342
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Tooze, Shenker, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Hazelett's order that dismissed his request for hearing. On review, the issue is dismissal. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable injury on February 26, 1991. The insurer accepted the claim for a cervical/thoracic strain, but denied compensability of claimant's degenerative disc disease and preexisting compression fractures. Claimant retained attorney Zachary Zabinsky, who timely filed a request for hearing. Approximately three weeks prior to August 20, 1991, the original hearing date, Mr. Zabinsky withdrew representation. Claimant requested and received a postponement of the hearing in order retain new legal counsel.

The hearing was rescheduled for January 21, 1992. On the date of hearing, claimant telephoned the Referee's secretary and advised her that he had not retained new counsel but that he intended to appear and represent himself at hearing. Later that afternoon, claimant called and spoke to the Referee. The Referee advised claimant that he could appear pro se, but claimant replied that he had decided not to appear. The Referee then advised claimant that his case would be dismissed if he did not appear and that he would have to prove extraordinary circumstances in order to overcome the dismissal.

Claimant did not appear at the time scheduled for hearing. The insurer subsequently moved for a dismissal of claimant's request for hearing, which the Referee granted. Thereafter, claimant, through his recently obtained counsel, sought reconsideration of the Referee's dismissal order. Noting that claimant had only recently retained his legal counsel, claimant sought abatement of the dismissal order so he could have his "day in court."

CONCLUSIONS OF LAW AND OPINION

The Referee denied claimant's request to reconsider the order that dismissed claimant's hearing request. The Referee found that claimant failed to appear at the scheduled hearing and that he failed to prove extraordinary circumstances that would have justified postponement. We agree.

If a party requests a hearing and then fails to appear, the referee shall dismiss the request for hearing as having been abandoned unless extraordinary circumstances justify postponement or continuance of the hearing. OAR 436-06-071(2). In order to obtain a postponement of a hearing, the moving party must show extraordinary circumstances beyond the party's control. ORS 656.283(4). The unavailability of a party due to an unwillingness to appear does not constitute extraordinary circumstances. OAR 438-06-081(2).

In this case, claimant offers no reason for his failure to appear other than his apparent realization on the date of hearing that he needed legal counsel. The record reveals, however, that claimant had

from early August 1991 to January 21, 1992 to retain new counsel. His unexplained failure to do so does not constitute extraordinary circumstances to warrant another postponement of the hearing.

ORDER

The Referee's orders dated January 23, 1992 and February 12, 1992 are affirmed.

October 30, 1992

Cite as 44 Van Natta 2222 (1992)

In the Matter of the Compensation of
BRENTON R. KUSCH, Claimant
WCB Case No. 91-12241
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of Referee Neal's order that: (1) found that claimant was medically stationary on August 7, 1990; (2) concluded that his claim had not been prematurely closed by a Determination Order; and (3) affirmed an Order on Reconsideration award of no unscheduled permanent disability for a cervical/thoracic injury. On review, the issues are premature closure, medically stationary date, and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. At hearing, claimant stipulated that he had withdrawn his request for the appointment of a medical arbiter. (Tr. 2).

CONCLUSIONS OF LAW AND OPINION

Premature Closure/Medically Stationary Date

The Referee concluded that claimant was medically stationary on August 7, 1990 and, therefore, that his claim had not been prematurely closed by the December 5, 1990 Determination Order. We agree.

Claims shall not be closed if the worker's compensable condition has not become medically stationary. ORS 656.268(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Evidence that was not available at the time of closure may be considered to the extent the evidence addresses the condition at the time of closure. Schuening v. J.R. Simplot & Co., 84 Or App 622 625 (1987). It is claimant's burden to prove that his claim was prematurely closed. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The resolution of the medically stationary date is primarily a medical question based on competent medical evidence, although that evidence may be circumstantial. Harmon v. SAIF, 54 Or App 121, 125 (1981).

In this case, the insurer notified claimant on October 29, 1990 that, because he had not seen his physician regarding his work injury since August 7, 1990, it would assume that he had recovered without disability and submit the claim for closure unless it received word otherwise within two weeks. Claimant testified that he may have received this letter. In any event, the insurer received no response, and the claim was subsequently closed by a December 5, 1990 Determination Order, which found claimant medically stationary on November 12, 1990.

Apparently, the Determination Order was issued pursuant to former OAR 436-30-035(7). However, the version of this rule in effect at claim closure provides that "a worker shall be determined to be medically stationary on the earliest of the following dates:"

"(c) If the worker has not sought medical care for a period in excess of 28 days unless so instructed by the attending physician, on the date the worker last sought medical care." (WCD Admin. Order 7-1990).

There is no evidence that claimant's attending physician instructed him not to seek medical care. Thus, claimant's medically stationary date is August 7, 1990, the date he last saw Dr. Nelson. As discussed below, this date is supported by circumstantial medical evidence.

On August 7, 1990, Dr. Nelson, claimant's then treating physician, noted that claimant's cervical examination was normal with full range of motion. (Ex. 3). He released claimant for work without restrictions. The next day claimant returned to his job as a truck mechanic and performed that work until he was laid off two or three months later. Claimant did not return to Dr. Nelson for the final examination scheduled on September 10, 1990. (Ex. 6). Subsequently, Dr. Nelson moved out-of-state.

Claimant next sought medical treatment on December 18, 1990, at which time Dr. Mahmood, M.D., became claimant's attending physician. (Ex. 8, 9). Claimant reported that, subsequent to being laid off, he found another job and for the "last 3-4 weeks he has [had a] recurrence of neck pain." (Ex. 9). Claimant later sought treatment with Dr. Bachhuber, M.D. (Exs. 13, 15A). On October 22, 1991, Dr. Takacs, D.O., examined claimant and became claimant's attending physician. (Ex. 20, 21). After this initial examination, Dr. Takacs responded to claimant's attorney's November 29, 1991 check-the-box letter by indicating that claimant was medically stationary. (Exs. 21, 22-1).

On this record, we do not find that claimant has established that his claim was prematurely closed. Dr. Nelson's final chart note, claimant's return to regular work without restrictions, his lack of need for medical treatment until December 18, 1990, and his report of a recurrence of neck pain at that time all support a finding that he was medically stationary on August 7, 1990 and his claim was properly closed by the December 5, 1990 Determination Order. Although claimant treated with three physicians after he again sought medical treatment on December 18, 1990, none of these physicians gives an opinion as to his medically stationary status at the time of claim closure. Dr. Takacs' check-the-box response in December 1991 does not address claimant's medically stationary status in December 1990.

Extent of Unscheduled Permanent Disability

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 5, 1990. WCD Admin. Order 6-1988, as amended by WCD Admin. Orders 15-1990 and 20-1990 (temporary rules effective October 1, 1990 and November 20, 1990); see also OAR 438-10-010. These are the standards that we apply as well. The Referee found that claimant failed to establish any permanent impairment due to the compensable injury. We agree.

Before we address the extent of claimant's injury-related permanent disability, we must address two preliminary issues. The first concerns the validity of the administrative standards used to rate the extent of claimant's disability. Claimant argues that the rules in effect at the time of the December 5, 1990 Determination Order are invalid, because they were adopted in violation of the required rulemaking procedures. Therefore, he argues, his claim should be calculated pursuant to the previous standards. We recently rejected that argument and reaffirmed our previously held opinion that we have no authority to declare invalid a rule promulgated by the Director. Eileen N. Ferguson, 44 Van Natta 1811 (1992).

The second issue concerns our procedural authority to review the Order on Reconsideration. Although claimant requested reconsideration of the December 5, 1990 Determination Order on the basis of a disagreement with the impairment findings used in the rating of his disability, the Director failed to refer the matter to a medical arbiter as required by ORS 656.268(7). Under such circumstances, it would appear that the Director's Order on Reconsideration is invalid under our decision in Olga I. Soto, 44 Van Natta 697, recon den 44 Van Natta 1609 (1992). (Where Director fails to comply with mandatory procedure and one of the party objects to the order issued, the Order on Reconsideration is invalid.) At hearing, however, claimant stipulated that he had withdrawn his request for the appointment of a medical arbiter. Moreover, the insurer does not contest the validity of the Order on Reconsideration.

The question, therefore, is whether the parties' apparent waiver of the procedural defect can, in essence, validate the Order on Reconsideration for our review.

It is well understood that a jurisdictional requirement cannot be waived. Hoffman v. City of Portland, 294 Or 150 (1982); City of Hermiston v. Employment Relations Board, 280 Or 291 (1977). The failure of an agency to follow a mandatory procedure, however, may speak only to the validity of the action, rather than affecting an appellate body's jurisdiction for review. The court reached the latter conclusion in Patton v. State Bd. Higher Ed., 293 Or 363 (1982). In that case, a student was placed on mandatory medical leave pursuant to a university rule and sought judicial review. The Court of Appeals dismissed for lack of jurisdiction, holding that judicial review would have been available only if the university proceeding had qualified as a "contested case" under the Administrative Procedures Act. On review, the Supreme Court disagreed. While a contested case calls for certain administrative procedures, the Court explained that the "[f]ailure to follow those procedures in any given case may or may not be reversible error, but that goes to the merits, it does not control the court's jurisdiction." 293 Or at 366; See also SAIF v. Roles, 111 Or App 597 (1992).

We reach the same conclusion here. ORS 656.268(7) requires the Director to appoint a medical arbiter where a party requests reconsideration of a Determination Order or Notice of Closure on the basis of a disagreement with the impairment findings used in the rating of disability. Nonetheless, the Director's failure to comply with that mandatory procedure does not, in our opinion, necessarily render the ensuing order void ab initio, thereby precluding our jurisdiction for review. Rather, we believe that it merely resulted in an order which may be voided by a party which the mandatory provision is intended to protect. Because neither party objects to the Director's failure to appoint a medical arbiter, we find the Order on Reconsideration valid for review and proceed to consider the issue of the extent of claimant's injury-related permanent disability.

Claimant has the burden of establishing the nature and extent of any disability resulting from a compensable injury. ORS 656.266. Impairment must be established by medical evidence that is supported by objective findings. ORS 656.283(7); 656.295(5). Where there is no impairment under the rules, no award of scheduled or unscheduled permanent partial disability is allowed. Former OAR 436-35-010(3); 436-35-320(2). In this case, Dr. Nelson, claimant's last attending physician, made no findings of impairment and noted that claimant's cervical examination was normal. (Ex. 3).

Claimant argues that we should rely on a check-the-box opinion from Dr. Takacs, who became claimant's attending physician more than ten months after claim closure. In response to a letter from claimant's attorney, Dr. Takacs checked boxes indicating that claimant had a chronic condition that limited repetitive use of his neck, upper back, and left shoulder. However, because Dr. Takacs was neither the attending physician at claim closure nor a medical arbiter, we may not consider his findings. ORS 656.245(3)(b)(B); 656.268(7). Furthermore, given its conclusory nature, even if we considered Dr. Takacs' check-the-box opinion, we would find that it does not establish that claimant is entitled to an award for a chronic condition. See Barbara I. Norman, 43 Van Natta 2787 (1991), aff'd mem., 114 Or App 639 (1992).

On this record, we conclude that claimant has not established that the compensable injury resulted in permanent impairment.

ORDER

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

In the Matter of the Compensation of
JOSEPH W. MANLEY, Claimant
WCB Case Nos. 91-10636 & 91-09533
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Gail M. Gage (Saif), Defense Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Quillinan's order that: (1) upheld the SAIF's Corporation's denial of claimant's "new injury" claim for a left hip condition; (2) upheld Liberty Northwest Insurance Corporation's denial of claimant's aggravation claim for the same condition; and (3) declined to award a penalty and attorney fee for an alleged failure by both carriers to pay interim compensation. On review, the issues are responsibility, aggravation, and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact but correct that portion which found that Liberty denied the aggravation claim on August 15, 1991 to October 15, 1991.

CONCLUSIONS OF LAW AND OPINION

Responsibility

Under ORS 656.308(1), in cases in which an accepted injury is followed by an increase in disability during employment with a later carrier, responsibility presumptively rests with the original carrier unless the claimant sustains an actual, independent, compensable injury during the subsequent work exposure. Ricardo Vasquez, 43 Van Natta 1678, 1680 (1991). As the original carrier, therefore, Liberty presumptively remains responsible absent proof that claimant sustained an actual, independent, compensable injury during his work with SAIF's insured.

Liberty originally accepted a left hip and groin strain based on a March 1990 work incident. On June 16, 1991, claimant was walking at work and experienced an increase of symptoms in his left hip and groin. Claimant sought treatment from Dr. Cohen, orthopedic surgeon, who initially reported that, "[a]s a result of the [March 1990] accident, [claimant] sustained a strain of the left hip[.] * * * The second injury of June 16, 1991 is an aggravation of the first injury, which occurred March, 1990." (Ex. 27-3). Based on a bone scan, Dr. Cohen subsequently diagnosed claimant with degenerative arthritis of the left hip, as well as the possibility of avascular necrosis. (Ex. 30). In several reports, Dr. Cohen stated that, although the two work incidents had aggravated the degenerative condition and caused increased symptoms, they had not caused the condition, since it was preexisting, nor worsened it pathologically. (Exs. 30, 31, 36, 38, 38A). Dr. Cohen further indicated that the June 1990 incident "was not a new and separate injury[.]" (Ex. 31).

During a deposition, Dr. Cohen reiterated that he doubted that the two injuries had accelerated the degenerative arthritic condition or possible avascular necrosis; although he indicated that they could have caused claimant's symptoms to increase. (Ex. 42-11). Dr. Cohen also stated that the June 1991 incident was a continuation of the first injury rather than a new and separate injury. (Id. at 12).

Claimant also underwent an independent medical examination with Drs. Peterson, neurologist, and Fuller, orthopedic surgeon. The report found "[d]egenerative arthritis, left hip, pre-existing, but made symptomatic by the March, 1990 and June, 1991 work-related incidents." (Ex. 37-4). The report also recommended MRI scans of the lumbar spine and left hip, further stating that:

"[u]ntil we obtain the recommended tests and make a definitive diagnosis, it is difficult to firmly establish major contributing cause. We do find that there has been a change in his symptoms resulting from the June, 1991 injury as there has not only been increased discomfort but also new symptoms in the erectile dysfunction. Thus, it would appear that the June, 1991 incident is the major contributing cause for these new symptoms as well as for the current need for treatment." (Id. at 5).

After reviewing his records and a letter from Liberty's counsel, Dr. Daack, D.O., who treated claimant for his March 1990 injury, reported that "the incident of 06-16-91 materially contributed to [claimant's] disability and need for further therapy. And has apparently caused [claimant's] left hip and groin problem to worsen. As to the problem with degenerative arthritis, I would hesitate to comment on such since I have not seen him for that or rendered therapy." (Ex. 39).

We first note that we give little weight to the opinion of Dr. Daack. He had not treated claimant since January 1991 when he rendered an opinion, and he based his opinion only on his own records and a letter from Liberty, which is not contained in the record. Furthermore, Dr. Daack does not comment on the contribution to claimant's symptoms from the degenerative arthritic condition, which Dr. Cohen found was the cause of his symptoms.

Moreover, as the treating physician, we give more weight to the opinion of Dr. Cohen rather than that of Drs. Peterson and Fuller. See Weiland v. SAIF, 64 Or App 810 (1983). Furthermore, the report of Drs. Peterson and Fuller preceded the opinion regarding causation with the statement that, in the absence of further test results, they could not provide a definitive diagnosis or a firmly established opinion regarding causation. We find that these statements indicate that Drs. Peterson and Fuller were providing only a possible, rather than probable, opinion regarding a causal connection, further lessening the weight to be accorded to their opinion. See Gormley v. SAIF, 52 Or App 1055, 1060 (1981).

Pursuant to the opinion of Dr. Cohen, we conclude that claimant did not sustain an actual, independent, compensable injury at the time of the June 1991 episode. Rather, Dr. Cohen indicated that claimant's increased symptoms at that time were a continuation of his condition in March 1990 in that the June 1991 event also symptomatically aggravated claimant's degenerative arthritic condition. Therefore, we conclude that responsibility does not shift to SAIF but remains with Liberty. We proceed to address whether or not claimant established a claim for aggravation against Liberty.

Aggravation

In order to prove a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. See ORS 656.273(1). As stated above, Liberty initially accepted a claim for a left hip and groin strain. Although the record demonstrates that claimant suffered increased symptoms following the June 1991 episode, we conclude that the symptoms were due to his degenerative arthritic condition and, therefore, any worsening was not a result of the original injury.

We again place the greatest weight on the opinion of Dr. Cohen. He specifically stated that, although the June 1991 event aggravated claimant's arthritic condition, claimant's worsening left hip condition is "mostly" due to the preexisting degenerative condition rather than work-related injuries. (Ex. 36; 42-15, 17). Therefore, we conclude that the major contributing cause of claimant's need for treatment and disability is his preexisting arthritic condition. Therefore, claimant's aggravation claim fails. ORS 656.005(7)(a)(B); ORS 656.273; Thomas L. Fitzpatrick, 44 Van Natta 877 (1992).

Penalties and Attorney Fees

Claimant contends that both Liberty and SAIF did not timely deny the claims and, therefore, he was entitled to interim compensation. Because neither carrier paid interim compensation, claimant asserts that he is entitled to a penalty and attorney fee.

"Interim compensation" is temporary disability payments made between the carrier's notice of the injury and the acceptance or denial of the claim. Bono v. SAIF, 298 Or 405, 407 n 1 (1984). In cases of initial injury claims, interim compensation must be paid no later than the 14th day after the carrier's notice or knowledge of a medically verified inability to work due to the injury. See id. at 408. In cases of aggravation claims, interim compensation must be paid no later than the 14th day after the carrier's notice or knowledge of a medically verified inability to work due to a worsened condition. Avalos v. Bowyer, 89 Or App 546 (1988).

Claimant initially filed a claim with Liberty on June 18, 1991. On June 26, 1991, Liberty issued a denial. On October 15, 1991, Liberty issued a second denial. The first denial was withdrawn at the

time of hearing. On July 23, 1991, claimant filed a claim with SAIF; that claim was received on July 24, 1991. SAIF issued a denial on August 6, 1991.

Dr. Cohen released claimant from work on July 2, 1991. We conclude that Dr. Cohen's report of the same date provides the first notice of a medically verified inability to work, whether because of a new injury or a worsened condition. The record reveals that this notice was not received by SAIF until July 24, 1991. Because SAIF denied the claim within 14 days of this notice, we conclude that SAIF was not obligated to pay interim compensation to claimant. There is no evidence, however, as to when or if Liberty received this notice. Therefore, we are unable to conclude that Liberty's October 15, 1991 denial was beyond the 14 days of notice or knowledge of a medically verified inability to work due to a worsened condition. Moreover, although withdrawn at the hearing, Liberty had issued a denial of the June 18, 1991 claim within the 14 days of the claim's filing. Consequently, we find that claimant failed to prove an entitlement to interim compensation from Liberty. There is no basis for awarding a penalty and attorney fee.

ORDER

The Referee's order dated February 25, 1992 is affirmed.

October 30, 1992

Cite as 44 Van Natta 2227 (1992)

In the Matter of the Compensation of
TIMOTHY O. REYNOLDS, Claimant
WCB Case No. 91-01831
ORDER ON REVIEW (REMANDING)
Myrick, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Brown's order that upheld the self-insured employer's denial of claimant's right wrist condition. Alternatively, claimant moves to remand the matter to the Referee for admission of further evidence concerning the post-hearing surgery. On review, the issues are remand and compensability. We remand.

FINDINGS OF FACT

In April 1989, claimant sustained an injury to his right wrist. After seeking treatment for persisting right wrist symptoms in January 1990, claimant initially was diagnosed with dorsal tenosynovitis. (Ex. 9). An independent medical examination diagnosed recurrent right wrist capsulitis with recurrent extensor tendinitis. (Ex. 20). The latter condition was accepted by the employer. (Ex. 27).

Claimant then was examined by Dr. Appleby, orthopedic surgeon. After ordering an arthrogram and MRI, Dr. Appleby referred claimant to Dr. Buehler, hand surgeon, who diagnosed scapholunate dissociation and recommended arthroscopic surgery. (Ex. 44). Before responding to the request for surgery, the employer scheduled claimant for an independent medical examination with Dr. Nathan, hand surgeon. Dr. Nathan diagnosed a ganglion in the right wrist and bilateral, congenital, hypermobile wrists. (Ex. 51-6). Dr. Nathan also found that other diagnoses were not confirmed by his examination or radiological findings. (*Id.*). Finally, Dr. Nathan found it "possible" that the April 1989 accident could have caused the ganglion. (*Id.*)

Dr. Buehler reported that claimant could have a ganglion, although he continued to opine that he also had scapholunate instability, which was caused by the industrial accident. (Ex. 56). Dr. Appleby rejected the diagnosis of a ganglion and concurred with Dr. Buehler's diagnosis. (Ex. 53).

The employer denied compensability of a claim for mid-carpal instability or scapholunate dissociation. (Ex. 67). Claimant requested a hearing from that denial. The Referee, giving more weight to the opinion of Dr. Nathan, concluded that claimant had failed to prove that his symptoms were due to a scapholunate dissociation and upheld the employer's denial.

CONCLUSIONS OF LAW AND OPINION

Claimant moves for remand in order to admit evidence that, after the hearing, claimant underwent a ganglionectomy by Dr. Nathan and that this surgery revealed the presence of a ganglion in his right wrist. Claimant also seeks remand to admit evidence that, although his ganglion was surgically removed, his symptoms persist unabated. The employer opposes the motion.

We have no authority to consider evidence not already included in the record. Under ORS 656.295(5), our only statutory power is to remand the case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See Bailey v. SAIF, 296 Or 41, 45 n 3 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988) (approving applicability of Compton v. Weyerhaeuser Co., *supra*, to remand by the Board).

We find that claimant has established a compelling reason to grant the motion for remand. The evidence concerning claimant's surgery and subsequent condition involves claimant's disability and, because the surgery was not performed until after hearing, was not obtainable at the time of hearing. Furthermore, we conclude that such evidence is reasonably likely to affect the outcome of the case, because it goes directly to the questions as to whether claimant suffers from a ganglion or scapholunate dissociation, or both, and whether claimant's symptoms are caused by one or the other conditions.

Therefore, we remand to the Referee for the admission of additional evidence regarding claimant's post-hearing surgery. In addition, the Referee shall allow the employer an opportunity to cross-examine or rebut this late-produced evidence. The submission of this additional evidence shall be made in any manner that the Referee determines will achieve substantial justice.

Accordingly, the Referee's order dated June 7, 1991 is vacated. This matter is remanded to Referee Brown for further proceedings consistent with this order. Following these further proceedings, the Referee shall issue a final, appealable order.

IT IS SO ORDERED.

October 30, 1992

Cite as 44 Van Natta 2228 (1992)

In the Matter of the Compensation of
BEN SANTOS, Claimant
WCB Case Nos. 91-08869 & 91-02704
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Roberts, et al., Defense Attorneys
James Dodge (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation, on behalf of Press Specialties, Inc. (SAIF/Press), requests review of that portion of Referee Lipton's order that assessed penalties of 25 percent of the amount of compensation due at the date of the order for an unreasonable denial of compensability and an unreasonably late denial. Claimant cross-requests review of that portion of the Referee's order that: (1) declined to set aside SAIF/Press' allegedly unreasonable "de facto" denials of claimant's September 1988 and June 1990 aggravation claims; and (2) declined to assess penalties and attorney fees for those allegedly unreasonable "de facto" denials. SAIF/Press moves the Board for an order striking claimant's respondent's/cross-appellant's brief on the ground that it was not timely filed. On review, the issues are motion to strike, aggravation, penalties, and attorney fees. We deny the motion to strike, affirm in part, and modify in part.

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).

Motion to Strike

SAIF/Press has moved to strike claimant's respondent's/cross-appellant's brief on the basis that it was not filed within 21 days of the mailing of its April 6, 1992 appellant's brief. It relies, in part, on the April 29, 1992 postmark on the envelope sent to it containing the respondent's/cross-appellant's brief. We deny the motion.

Here, claimant's respondent's/cross-appellant's brief was due on April 27, 1992. OAR 438-05-046(1)(c) provides that briefs filed with the Board are timely filed if mailed by "first class mail, postage prepaid. An attorney's certificate that a thing was deposited in the mail on a stated date is proof of mailing on that date." SAIF/Press notes that the certificate of service accompanying the brief sent to it indicated that the respondent/cross-appellant's brief was mailed to the Board on April 28, 1992. Thus, SAIF/Press argues, the respondent/cross-appellant's brief was untimely. However, the certificate of service attached to the respondent's/cross-appellant's brief sent to the Board indicates that it was deposited in the mail to the Board on April 27, 1992. Accordingly, under the applicable administrative rule, claimant's respondent's/cross-appellant's brief was timely filed. Duane R. Paxton 44 Van Natta 375 (1992).

Penalty for Unreasonable Denial of Compensability and Unreasonably Late Denial

On March 28, 1991, SAIF/Press was notified that: (1) SAIF, as the insurer for Caryall Transport, Inc. (SAIF/Caryall), had denied responsibility for claimant's condition; and (2) claimant was making an aggravation claim against SAIF/Press. SAIF/Press denied compensability, responsibility, and the aggravation claim on August 27, 1991, more than 90 days after it received notice of the claim. The Referee found that: (1) SAIF/Press' denial was untimely; and (2) its denial of compensability was unreasonable. For these unreasonable denials, he assessed penalties of 25 percent of the amounts due at the date of his order, and directed that this penalty be split between claimant and claimant's attorney in lieu of an attorney fee. ORS 656.262(10). We modify.

Unreasonable Denial of Compensability

The Referee found that SAIF/Press' denial of compensability was unreasonable and prevented the appointment of a paying agent pursuant to ORS 656.307. SAIF/Press argues that its denial of compensability was not unreasonable because: (1) there is no evidence that claimant attempted to have a paying agent appointed; and (2) SAIF/Caryall also denied compensability. We find SAIF/Press' arguments to be without merit.

ORS 656.307(1) does not require that claimant request a paying agent. Instead, it provides that "the director shall, by order, designate who shall pay the claim, if the employers and insurers admit that the claim is otherwise compensable." (Emphasis added). Thus, unless the insurers admit the claim is compensable, a request for a paying agent will not be granted.

Furthermore, the fact that SAIF/Caryall also denied compensability does not absolve SAIF/Press of its liability for unreasonably denying compensability. In fact, the Referee assessed a separate penalty against SAIF/Caryall for its unreasonable denial of compensability.

More to the point, the record establishes that SAIF/Press had no legitimate basis to doubt compensability as to some employer at the time of its denial of compensability. The reasonableness of a carrier's denial of compensation must be gauged based upon the information available to the carrier at

the time of its denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n.3 (1985). Here, all of the reports, both before and after SAIF/Press' denial, relate claimant's current back condition to either the 1987 work injury or the 1991 work injury. (Exs. 32, 33, 34, 36, 37, 43, 45, 47, 48). Thus, SAIF/Press' denial of compensability was unreasonable.

We find our recent decision in Harold R. Borron, 44 Van Natta 1579 (1992), directly applicable to the present case. In Borron, although we upheld the insurer's denial of responsibility for a knee condition, we found that the insurer had unreasonably denied compensability of that condition because there was no evidence that the condition was not work-related. Relying on Kim S. Jeffries, 44 Van Natta 419 (1992), we assessed a penalty for this unreasonable compensability denial based on all compensation due at the time of hearing, including medical services.

For SAIF/Press' unreasonable compensability denial, a penalty will be assessed equal to 25 percent of all compensation due as of the hearing, including medical services. Harold R. Borron, *supra*, Kim S. Jeffries, *supra*. Thus, we modify the Referee's penalty assessment to the extent that it assessed penalties through the date of his order rather than the date of hearing.

Untimely Denial

SAIF/Press concedes that its denial of claimant's aggravation claim was untimely and provides no explanation for the untimeliness. (Ex. 46). Also, SAIF/Press does not dispute that the April 1, 1991 report from Dr. Peterson, examining neurologist, and Dr. Coletti, examining orthopedist, establishes claimant's inability to work due to the compensable 1987 injury. Instead, SAIF/Press' sole argument is that there are no amounts "then due" upon which to base a penalty because claimant did not meet his burden of proving the date that SAIF/Press was notified of claimant's inability to work so as to trigger its duty to pay interim compensation. It argues that there is no evidence that the claims examiner responsible for the claim against SAIF/Price received the April 1991 report. We do not find SAIF/Press' argument persuasive.

A carrier is obligated to pay interim compensation on an aggravation claim beginning no later than 14 days after the carrier receives medical verification of an inability to work due to a compensable worsening supported by objective findings, and continuing until a formal denial of the claim is issued. ORS 656.262(4); 656.273(6); Doris A. Pace, 43 Van Natta 2526 (1991).

Here, claimant filed his aggravation claim against SAIF/Press on March 28, 1991. Thereafter, the claims adjuster for the SAIF/Caryall claim received the April 1991 report authored by Drs. Peterson and Coletti which implicated the 1987 injury with SAIF/Press as being responsible for claimant's current condition, including his inability to work. (Ex. 43).

SAIF/Press argues that, because the April 1991 report was sent to SAIF's claims adjuster for the Caryall claim, rather than to SAIF's claims adjuster for the Press claim, SAIF did not have notice of claimant's inability to work. We disagree.

The Court of Appeals has held that an employer's conduct in initially denying that a claim is work related and in failing to report the claim in a timely manner is legally imputable to its insurer. See Nix v. SAIF, 80 Or App 656 (1986), *rev den* 303 Or 158 (1987). We find Nix v. SAIF, *supra*, analogous to the present case.

Here, the claims adjuster for SAIF/Caryall relied on the earlier compensable injury at SAIF/Press in denying responsibility for the claim. (Ex. 41). In addition, the April 1, 1991 medical report received by the claims adjuster for SAIF/Caryall explicitly identifies the 1987 work injury with SAIF/Press as being responsible for claimant's current condition. (Ex. 43). Under these circumstances, SAIF's claims adjuster for Caryall had a duty to forward a copy of the April 1991 medical report to his colleague who was handling the Press claim. The routing of this report to the SAIF/Caryall claims adjuster does not absolve SAIF/Press of its claims processing duties. In other words, SAIF cannot rely on the fact that the April 1991 report was sent to the desk of one claims adjuster within the SAIF organization rather than another to assert that it never received notice of claimant's inability to work. It is not claimant's duty to see that a specific claims adjuster within the SAIF organization receives medical verification of his inability to work. Claims processing is the duty of the insurer, not claimant.

Therefore, we agree that SAIF/Press' untimely denial and failure to pay interim compensation was unreasonable and find that the unpaid interim compensation provides an amount "then due" upon which to base a penalty. The Referee allowed no additional penalty for SAIF/Press' untimely denial and failure to pay interim compensation because the maximum penalty had been assessed for SAIF/Press' unreasonable denial of compensability. ORS 656.262(10)(a); Mollie E. Barrow, 43 Van Natta 617, 618 (1991). We agree that no additional penalty may be based on the untimely denial and failure to pay interim compensation but find that an assessed attorney fee is allowed pursuant to ORS 656.382(1).

Under ORS 656.262(10)(a), a claimant is not entitled to both a penalty and an attorney fee under ORS 656.382(1) for the same processing infraction. Martinez v. Dallas Nursing Home, 114 Or App 453 (1992); Ronald A. Stock, 43 Van Natta 1889 (1991). However, SAIF/Press' unreasonable denial of compensability is unreasonable conduct that is separate and distinct from its untimely denial of the claim and its failure to pay interim compensation. By untimely denying the claim and failing to pay interim compensation, SAIF/Press unreasonably resisted the payment of compensation. See ORS 656.382(1). Thus, claimant is entitled to an attorney fee, as well as a penalty based on the unreasonable denial of compensability.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 concerning the untimely denial and failure to pay interim compensation is \$500, to be paid by SAIF/Press. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by appellant's brief and the hearing record), the complexity of the issue, and the value of the interest involved.

Alleged Aggravation Claims in September 1988 and June 1990

The Referee found that claimant had not established compensable aggravation claims in September 1988 and June 1990 regarding the 1987 work injury. Therefore, he upheld SAIF/Press' "de facto" denials of these alleged aggravation claims. We agree.

To establish an aggravation claim, "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 (1991); Herman M. Carlson, 43 Van Natta 963, 964 (1991). This report must establish a causal connection between claimant's noted condition and compensable injury. Carlson, supra at 964; Michael L. Page, 42 Van Natta 1690, 1693 (1990). However, the report need not establish the nonmedical aspects of an aggravation claim, i.e., reduced earning capacity. Carlson, supra at 964.

By letters dated September 16, 1988 and January 9, 1989, Dr. Lininger, treating chiropractor, opined that claimant had suffered an "aggravation" and an "exacerbation." (Exs. 20, 26). However, he provided no objective medical findings in support of that opinion. On October 24, 1988, Dr. Franks, consulting neurologist, examined claimant and described ongoing symptoms dating from the July 1987 work injury. (Ex. 23-1). However, he did not describe any worsening of the symptoms. Dr. Franks also noted that claimant's MRI was well within normal limits. (Exs. 24, 25). Thus, we find that these reports do not establish a prima facie case in the form of objective findings that claimant's compensable condition has medically worsened.

On June 6, 1990, claimant returned to Dr. Franks who noted that claimant had "more pain across his low back, both buttocks, posterior thighs to the knee." (Ex. 29). A June 12, 1990 MRI showed no changes. (Ex. 30). However, during the October 1988 examination in which claimant reported only ongoing symptoms, claimant had no pain down the left posterior thigh. (Ex. 23-1). Although these reports represent a symptomatic worsening, Dr. Franks does not relate this worsening to the

¹ We note that SAIF/Press' failure to pay interim compensation was an issue at hearing. Furthermore, the Referee addressed this issue in his opinion, finding that SAIF/Press offered no explanation for its failure to pay interim compensation despite claimant's inability to work. However, the Referee neglected to award interim compensation in his order language. As explained above, we find that the April 1, 1991 medical report established SAIF/Press' duty to begin paying interim compensation. This duty continued until SAIF/Press denied the aggravation claim on August 27, 1991. We will order payment of interim compensation accordingly.

compensable injury. Likewise, Dr. Lininger's release from work for a week provides no causal relationship to the compensable injury. (Ex. 31).

We conclude that the medical reports do not establish a prima facie evidence of an aggravation claim. Since there was no claim, there was nothing for SAIF/Press to accept or deny. We find that SAIF/Press' conduct in this instance was not unreasonable, and no penalties or attorney fees are assessed.

ORDER

The Referee's order dated December 5, 1991, as reconsidered on January 2, 1992, is modified in part and affirmed in part. Claimant is awarded interim compensation from April 1, 1991 through August 27, 1991, payable by the SAIF Corporation, as the insurer for Press Specialties (SAIF/Press). 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 the Board from this compensation shall not exceed \$3,800. Regarding the penalty for SAIF/Press' unreasonable denial of compensability, in lieu of the 25 percent penalty based on all compensation due at the date of the Referee's order, claimant is awarded a penalty of 25 percent of all compensation due at the date of the hearing, to be split equally between claimant and his attorney. Claimant's attorney is awarded an attorney fee of \$500 for his services concerning SAIF/Press' untimely denial and failure to pay interim compensation. The remainder of the order is affirmed.

October 30, 1992

Cite as 44 Van Natta 2232 (1992)

In the Matter of the Compensation of
GLORIA J. SHELTON, Claimant
WCB Case No. 91-10458
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of Referee McWilliams' order that rejected claimant's request for carrier-paid attorney fees under ORS 656.386(1). On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

Claimant compensably injured her knee. On June 10, 1991, the claim was reopened and temporary total disability benefits were paid from February 13, 1991 to April 9, 1991. On June 20, 1991, claimant underwent knee surgery. On August 6, 1991, claimant's attorney requested payment of temporary total disability benefits in connection with the surgery. SAIF responded that it had not received any verification from the treating physician of time loss. After SAIF received verbal authorization, on August 29, 1991, payment of temporary total disability commenced.

On January 2, 1992, the parties entered into an Interim Stipulation, providing that SAIF would pay a 25 percent penalty for late payment of time loss, one-half of the amount granted to claimant's attorney as an attorney fee. Claimant thereafter limited a previously filed request for hearing to alleging that her attorney was entitled to an attorney fee under ORS 656.386(1) because he had been instrumental in obtaining compensation and a hearing had not been held.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the 1991 amendments to ORS 656.386(1) had not modified the prior law holding that the statute was not applicable when the dispute concerned only the amount of compensation or extent of disability rather than whether claimant's condition was caused by an industrial injury. The Referee concluded that the dispute between SAIF and claimant regarding the payment of temporary total disability benefits was limited to the type or quantity of compensation and, therefore, found ORS 656.386(1) to be inapplicable.

Claimant challenges the Referee's conclusions on several bases. First, claimant disputes the Referee's interpretation of ORS 656.386(1), asserting that the legislature intended to create an entirely new form of assessed attorney fees for settlement situations when it modified the statute in 1991 to allow for an assessed attorney fee when "an attorney is instrumental in obtaining compensation for a claimant and a hearing before the referee is not held." Claimant contends that, based on the statute's plain language, claimant need only prove that an attorney was instrumental in obtaining compensation and that a hearing was not held in order to become entitled to an assessed fee. Claimant argues that prior holdings concerning the statute cited by the Referee are no longer applicable. We disagree.

Prior to 1991, ORS 656.386(1) provided:

"In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or petition for review to the Supreme Court from an order or decision denying the claim for compensation, the court shall allow a reasonable attorney fee to the claimant's attorney. In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee. In the event a dispute arises as to the amount allowed by the referee or board or appellate court, that amount shall be settled as provided for in ORS 656.388(2). Attorney fees provided for in this section shall be paid by the insurer or self-insured employer."

According to the Supreme Court, "[w]here the only compensation issue on appeal is the amount of compensation or the extent of disability, rather than whether the claimant's condition was caused by an industrial injury, [former] ORS 656.386(1) is not the applicable attorney fee statute[.]" Short v. SAIF, 305 Or 541, 545 (1988). In addition to caselaw, the Court based this rule of law on the statute's provision for attorney fees on review of denied claims only. Because the Referee and the Board had found that the claimant's condition was compensable, the court determined that the claimant did not appeal to the Board or to the Court of Appeals from a decision denying her claim. Id. Cf. Ohlig v. FMC Marine & Rail Equipment, 291 Or 586, 592-95 (1981) (finding that claimant was entitled to an attorney fee under ORS 656.386(1) because the employer disputed the issue of causation and distinguishing between prior cases that denied a fee where the question was the amount of compensation due for an injury which both parties agreed was compensable).

In 1991, the legislature modified ORS 656.386(1) by replacing the sentence pertaining to dispute resolution under ORS 656.388(2) with the following: "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." As did the Referee, we conclude that this current version of the statute should continue to be interpreted as provided in Short.

First, we understand claimant to argue that the 1991 amendment created a new class of assessed attorney fees only in the situation where compensation is obtained and a hearing is not held; therefore, claimant appears to contend that Short v. SAIF would continue to apply in all other cases of denied claims. We find no basis in the statute for justifying such a bifurcated application. Rather, we conclude that the statute must be read in its entirety. The disputed portion of the statute is preceded by those provisions allowing for an attorney fee where the claimant finally prevails on appeal from "an order or decision denying the claim for compensation" and "in such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself". Those provisions have been interpreted as limiting the applicability of the statute to denied claims. Short v. SAIF, supra. We conclude that the statute is most reasonably interpreted as also limiting to denied claims the availability of assessed attorney fees when an attorney is instrumental in obtaining compensation and a hearing is not held. That is, if this portion of the statute is satisfied, entitlement to an assessed fee is warranted only when the issue of causation is disputed and not merely the amount of compensation or extent of disability.

Our conclusion is supported by the recent decision in Simpson v. Skyline Corp., 108 Or App 721 (1991). In that case, the employer denied the claimant's vocational services claim. The claimant's attorney sought review by the Director. The Director issued an order requiring the insurer to refer the claimant to a vocational counselor for an eligibility evaluation, and, if the claimant was found to be eligible, for services. The claimant was found to be eligible for services. Simpson, supra.

In Simpson, the Court of Appeals addressed whether or not claimant was entitled to an assessed attorney fee under the current version of ORS 656.386(1) for his attorney's efforts in successfully overturning the employer's denial of his claim for vocational services. Applying Short v. SAIF, supra, the court found that ORS 656.386(1) was not applicable because "the question of whether claimant is entitled to vocational assistance concerns only the availability of a certain type of benefit, rather than whether claimant's condition was caused by his industrial injury[.]" 108 Or App at 723-24. Thus, the court indicated the 1991 amendment to the statute had not affected prior caselaw regarding its applicability.

Claimant argues that Simpson is distinguishable from this case and, thus, should not be relied upon in construing ORS 656.386(1). Specifically, claimant asserts that establishing eligibility to vocational services "is a prerequisite to the receipt of vocational services, but is not, in and of itself, compensation awarded to claimant. Neither is the insurer's finding of ineligibility a denial of compensation."

We understand claimant to contend that, because the Simpson case concerned eligibility to vocational services, the claimant's attorney did not obtain "compensation" and, therefore, ORS 656.386(1) was not applicable. However, the Simpson court clearly did not decide the case on the basis that vocational services did not constitute compensation; rather it explicitly stated that the statute was not applicable because the issue of causation was not in dispute. Therefore, we reject claimant's contention regarding Simpson.

Next, claimant argues that she made a written claim for compensation when she notified SAIF that she had been off work due to surgery. Furthermore, claimant contends that this claim was "de facto" denied when SAIF did not timely accept or deny the claim. Finally, claimant asserts that, "[w]here a written claim for compensation has been 'de facto denied' by virtue of the failure of the insurer to process within the time allowed by ORS 656.262, it is not necessary for the claimant to establish that the insurer disputes a causal relationship between the compensable injury and the subsequently claimed temporary total disability. That dispute is presumed by virtue of the insurer's 'de facto denial'." Essentially, therefore, claimant maintains that the question of causation was at issue and the case constituted a denied claim for purposes of ORS 656.386(1).

Even assuming that a "de facto" denial issued in this case, we find no support, and none is cited by claimant, for the assertion that causation was automatically put into dispute. Furthermore, those cases addressing the applicability of ORS 656.386(1) clearly indicate that resolution of whether or not causation is in dispute depends on whether the issue was actually raised by one or both of the parties. See e.g. Ohlig v. FMC Marine & Rail Equipment, supra. Therefore, we conclude that the record must indicate that a party is disputing causation in order for ORS 656.386(1) to be applicable.

Here, the Referee found, and we agree, that SAIF delayed payment of temporary total disability benefits on the basis that there had been no verification from claimant's treating physician authorizing time loss. There is no indication in the record that SAIF was denying payment of such benefits on the basis that claimant's time loss was not due to her compensable condition. Consequently, we conclude that causation was not at issue and this was not a denied claim. Therefore, ORS 656.386(1) is inapplicable and can provide no basis for an assessed attorney fee. See Jack A. Gates, 44 Van Natta 2078 (1992).

Finally, claimant contends that she asserted a right to receive an attorney fee under ORS 656.386(2) before the Referee and that it was "gross error" for the Referee to decline to award any attorney fee. We disagree. First, in reviewing the claimant's closing argument to the Referee, we find no assertion based on ORS 656.386(2). Furthermore, we have held that, when a carrier has paid compensation ordered by a Referee and that order did not provide for an approved fee out of the compensation, it is inequitable for the Board to require the payment of such a fee. Kenneth V. Hambrick, 43 Van Natta 1287, on recon 43 Van Natta 1637 (1991).

Here, after receiving verbal authorization of time loss, SAIF paid temporary total disability. Moreover, the parties entered into a stipulation providing that SAIF would pay a 25 percent penalty for late payment, half of the amount going to claimant's attorney. Because SAIF has paid the compensation

and in the absence of any previous provision for an approved fee out of this compensation, we decline to award an attorney fee on review under ORS 656.386(2).

ORDER

The Referee's order dated January 14, 1992 is affirmed.

October 30, 1992

Cite as 44 Van Natta 2235 (1992)

In the Matter of the Compensation of
RONALD J. STULL, Claimant
WCB Case Nos. 90-20735 & 90-20734
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Referee Kinsley's order which: (1) set aside its denial of claimant's claim for a left knee osteoarthritis condition; and (2) upheld EBI Companies' (EBI) denial of claimant's claim for the same condition. Liberty also requests that we clarify the Referee's order to indicate that only claimant's left knee condition was at issue here. In its respondent's brief, EBI contends that Liberty is precluded from denying compensability of claimant's left knee osteoarthritis condition because its "back-up" denial was impermissible. On review, the issues are propriety of Liberty's "back-up" denial, compensability and responsibility. We affirm in part and reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for her first and third "Ultimate Findings of Fact," with the following supplementation.

Claimant's work activities with the employer, while Liberty and then EBI were on the risk, were the major contributing cause of claimant's left knee osteoarthritis condition and need for left knee replacement.

The onset of claimant's left knee disability due to his compensable osteoarthritis condition occurred while EBI was on the risk.

CONCLUSIONS OF LAW AND OPINION

Left Knee Clarification

In drafting her order, the Referee made several references to claimant's right knee. Liberty contends that that these references are an oversight because, while the medical evidence indicates that claimant also has a right knee osteoarthritis condition, at the time of the hearing the right knee issue was not as yet "ripe." We agree that the right knee condition was not at issue. Consequently, we herein clarify the Referee's order by correcting all references to the "right knee" to read "left knee," with the exception of the reference on page 6, paragraph two.

"Back-up" Denial

At hearing, claimant contended that he was entitled to a penalty and related attorney fee because Liberty's January 21, 1991 denial (Ex. 25) of claimant's left knee osteoarthritis was an impermissible "back-up" denial. The Referee found that Liberty had not accepted claimant's condition as part of the May 4, 1987 injury claim and that Liberty's denial was not an impermissible "back-up" denial. The Referee consequently concluded that claimant was not entitled to a penalty and related

attorney fee. EBI now contends on review that, because Liberty never limited its acceptance of claimant's 1987 left knee injury claim, Liberty's subsequent denial of claimant's left knee osteoarthritis condition was an impermissible "back-up" denial. We disagree, and adopt the Referee's conclusions and reasoning as to this issue.

Compensability

This case involves an accepted compensable left knee injury while Liberty was on the risk, followed by an increase in disability after EBI became the employer's insurer. In cases such as this, where Liberty and EBI both denied compensability and responsibility, the threshold issue is compensability. Brent N. Jacobson, 43 Van Natta 87 (1991).

The Referee found that claimant's May 4, 1987 compensable injury with Liberty was a material contributing cause of his left knee osteoarthritis condition and, therefore, concluded that his left knee condition was compensable. We agree that the claim is compensable but substitute the following analysis.

We find that claimant's underlying osteoarthritis condition was already present when he suffered his 1987 compensable injury. (Ex. 4). We also find that his preexisting osteoarthritis combined with the compensable injury to cause or prolong disability or need for treatment. (Id.). Consequently, claimant must prove that his compensable injury was the major contributing cause of his resulting left knee osteoarthritis condition. ORS 656.005(7)(a)(B); Bahman M. Nazari, 43 Van Natta 2368 (1991). Here, 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), rev den 300 Or 546 (1986).

The record contains three independent medical examiners' reports and the opinion of Dr. Becker, claimant's treating surgeon. On behalf of Medical Consultant's Northwest, Dr. Dinneen, an orthopedist, and Dr. Reimer, a neurologist, opined that, while claimant's 1987 compensable injury increased the wear and degenerative changes, his current condition was caused principally by the degenerative process. (Ex. 16A-4). Later, Dr. Dinneen additionally opined that the 1987 injury had no more than a minimal effect and that the major contributing cause of claimant's current condition and need for total knee replacement surgery was his preexisting osteoarthritis. (Ex. 24-1). Additionally, on behalf of BBV Medical Services, Dr. Ayers, an orthopedic surgeon, and Dr. Brooks, a neurologist, attributed claimant's need for total knee replacement to his preexisting degenerative joint disease. (Ex. 19-4). Finally, Dr. Becker opined that the 1987 injury made claimant's preexisting condition more symptomatic by extending the tear in his knee cartilage. (Ex. 27-8, 27-9).

Because no opinion attributes claimant's current condition and need for total knee replacement in major part to his 1987 compensable injury, we conclude that claimant has failed to establish that his injury was and remained the major contributing cause of his resultant disability and need for treatment. Accordingly, claimant's current condition is not compensably related to the 1987 injury.

Alternatively, claimant asserts that his current condition is the result of his work activities for the employer. We find that the onset of claimant's current condition was gradual rather than sudden and it was not an unexpected consequence of claimant's work activities. Consequently, we analyze his condition as an occupational disease. See James v. SAIF, 290 Or 343, 348 (1991); Valtinson v. SAIF, 56 Or App 184, 187 (1982).

In order to establish a compensable occupational disease claim, claimant must prove, by medical evidence supported by objective findings, that his work activities for the employer were the major contributing cause of his current left knee condition. See ORS 656.802(1)(c) and (2). "Major contributing cause" means an activity or exposure or combination of activities or exposures which contributes more to the onset or worsening of the condition than all the other activities, exposures, or explanations combined. See Dethlefs v. Hyster Co., 295 Or 298 (1983); David K. Boyer, 43 Van Natta 561 (1991). Again, we find that the cause of claimant's current condition is of sufficient medical complexity that we cannot decide it without expert medical opinion. Uris v. Compensation Department, supra; Kassahn v. Publishers Paper Co., supra.

In this regard, Dr. Ayers and Dr. Brooks opined that claimant's condition and need for surgery was the result of the natural progression of his degenerative joint disease caused by the "repetitive trauma from his life time of work." (Ex. 19-4, 19-5). Dr. Becker agreed with their opinion and opined that the major contributing cause of claimant's osteoarthritis and need for surgery was his heavy and repetitive work activities for the employer as a garbage collector over the last 18 or 19 years. (Exs. 15, 23, 27-14). Dr. Stewart also agreed with Dr. Ayers' and Dr. Brooks' opinion, opining that claimant's degenerative condition was a "naturally occurring event" and that this degeneration was the major contributing cause of claimant's current condition and need for treatment. (Ex. 21-4, 21-5). On the other hand, Dr. Dinneen concurred with Liberty's attorney's telephone conference record that claimant's osteoarthritis was a "naturally progressive condition" and that claimant's work activity as a garbage collector was not the type of activity that causes osteoarthritis. (Ex. 24-1).

When there is a dispute between medical experts, we generally give greater weight to the opinion of the treating physician absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find no persuasive reason not to defer to Dr. Becker's opinion. Dr. Becker has been claimant's treating physician since 1987 and is, therefore, in a better position to render an opinion as to the cause of claimant's current disability. See Givens v. SAIF, 61 Or App 490 (1983). Moreover, he was the first to diagnose claimant's condition and performed knee surgery following claimant's 1987 injury. Furthermore, we find Becker's opinion the most well-reasoned and thorough and consistent with claimant's testimony as to the repetitive nature of his work. (Tr. 15 and 28). See Somers v. SAIF, 77 Or App 259 (1986). Finally, his opinion is consistent with the opinion of by Dr. Ayers and Dr. Brooks, with whom Dr. Stewart also concurred.

Consequently, based on the opinion of Dr. Becker, we find that claimant has established that his work activities with the employer (while Liberty and EBI were on the risk) were the major contributing cause of his current left knee osteoarthritis condition and need for total knee replacement surgery. Accordingly, we conclude that claimant's occupational disease claim is compensable. See ORS 656.802(2).

Responsibility

Finding that claimant's May 4, 1987 injury while Liberty was on the risk materially contributed to claimant's left knee osteoarthritis, the Referee concluded that initial responsibility was fixed with Liberty. The Referee further concluded that, because Liberty failed to establish that claimant's employment while EBI was on the risk independently contributed to a pathological worsening of the claimant's condition, Liberty remained the responsible carrier. We disagree.

We have concluded that claimant's left knee osteoarthritis is not compensably related to the 1987 injury. Furthermore, subsequent to the Referee's order, we held that the 1990 amendments to the responsibility law (ORS 656.308) are inapplicable where, as here, there is no accepted condition and a determination must be made concerning the assignment of initial liability between successive carriers. See Eleanor G. Castrignano, 44 Van Natta 1134 (1992); Fred A. Nutter, 44 Van Natta 854 (1992). In such cases, as it did before the 1990 amendments, the last injurious exposure rule continues to operate to allocate responsibility. See id.

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 carrier at the time disability occurs is assigned liability for the disease. 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, 162 (1986).

Here, claimant was diagnosed as having osteoarthritis following his May 1987 compensable injury. Claimant underwent surgery in November 1987. However, the osteoarthritis itself did not necessitate the surgery. Dr. Becker stated in his deposition testimony that the purpose of the surgery he performed on claimant after the 1987 injury was to repair claimant's torn meniscus. (Ex. 27-4 to 27-6). He further stated that, even though he removed the osteocartilaginous body caused by the osteoarthritis, it was not necessary to do so and he would not have performed knee surgery for that purpose. (Id.).

Therefore, while claimant was off work and disabled following his 1987 surgery, we find that, because the surgical procedure relating to his osteoarthritis condition was incidental and did not necessitate the surgery, the November, 1987 surgery was not the onset of disability relating to the compensable osteoarthritis condition. Instead, we find the date of disability occurred when Dr. Becker took claimant off work on June 15, 1990 due to the swelling in his knee related to his osteoarthritis. (Ex. 15). Consequently, because EBI was on the risk at the onset of disability, EBI is initially responsible for claimant's left knee osteoarthritis condition.

In order to shift responsibility to Liberty, EBI must establish that the work conditions while Liberty was on the risk were the sole cause of the worsening of claimant's underlying condition, or that it was impossible for work conditions while EBI was on the risk to have caused the disease. FMC Corporation v. Liberty Mutual Ins. Co., 73 Or App 223 (1985).

In the present case, Drs. Becker, Ayers, and Brooks opined that claimant's work activities since April 1989, while EBI was on the risk, could have contributed to claimant's osteoarthritis and need for total knee replacement. (Ex. 23 and 19-5). Furthermore, none of the doctors stated that it was impossible for claimant's work activities after April 1989 to have contributed to his worsened condition. Therefore, we find no basis to transfer responsibility from EBI to Liberty and, accordingly, EBI remains responsible for claimant's compensable left knee osteoarthritis condition. For that reason, the Referee's attorney fee award to claimant's attorney shall be paid by EBI, rather than Liberty.

Attorney Fee on Review

Because claimant's right to compensation was at issue at hearing and, thus, at risk on review, and claimant's compensation was not reduced or disallowed, claimant is entitled to a carrier-paid fee for services rendered on review pursuant to ORS 656.382(2). See Destael v. Nicolai Co., 80 Or App 596 (1986); Tanya L. Baker, 42 Van Natta 2818 (1990); 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 \$1,000, to be paid by EBI. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value to claimant of the interest involved.

ORDER

The Referee's order dated May 17, 1991, as amended May 30, 1991, is reversed in part and affirmed in part. Liberty Northwest Insurance Corporation's denial is reinstated and upheld. EBI Companies' denial is set aside, and the claim is remanded to EBI for processing according to law. For services rendered on review, claimant's attorney is awarded an assessed fee of \$1,000, to be paid by EBI. The Referee's attorney fee award to claimant shall be paid by EBI, rather than Liberty. The remainder of the order is affirmed.

In the Matter of the Complying Status of
LAKE CREEK RANCH MOBILE HOME PARK

WCB Case No. 91-07139

and, In the Matter of the Compensation of

MARK WALTON, Claimant

WCB Case No. 91-11715

ORDER ON REVIEW

S. David Eves, Claimant Attorney

Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Myzak's order that found that claimant was not a subject worker. On review, the issue is whether claimant is a subject worker. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was a skilled worker, the employer did not exercise control over claimant, claimant provided his own tools and the employer did not withhold taxes or social security from claimant's paycheck. Applying the traditional right-to-control test, the Referee concluded that the factors weighed in favor of a finding that claimant was an independent contractor, rather than an employee. Accordingly, she concluded that claimant was not a subject worker and the employer was not responsible for claimant's injury or workers' compensation benefits. Although we agree with the Referee's conclusions under the traditional right-to-control analysis, we nevertheless reverse. We do so because of our conclusion that the traditional right-to-control test is no longer determinative.

In 1989, the legislature enacted a statutory formula for determining whether workers are employees or independent contractors. In accordance with ORS 656.005(29), "independent contractor" has the meaning for that term as provided in ORS 670.600 (former ORS 701.025). Also see OAR 436-50-030. The statute provides that, as used in provisions of certain chapters, including ORS 656, an individual or business entity that performs labor or services for remuneration shall be considered to perform the labor or services as an independent contractor if the enumerated standards are met. ORS 670.600(1)-(8).

We have interpreted ORS 670.600 to provide that, in order for a party to be considered an independent contractor, all eight of the provisions of ORS 670.600 must be met. Gregory L. Potts, 43 Van Natta 1347 (1991).

ORS 670.600(5) provides that an individual will be considered an independent contractor if, "payment for the labor or services is made upon completion of the performance of specific portions of the project or is made on the basis of an annual or periodic retainer." In the present case, claimant was paid an hourly wage, rather than being paid for the completion of specific portions of the storage sheds which he built.

Accordingly, because at least one of the provisions of ORS 670.600 has not been met in this case, claimant is not an "independent contractor" as defined by the statute and used in ORS Chapter 656. See Gregory L. Potts, supra. Consequently, we conclude that he is a subject worker and the employer is responsible for workers' compensation benefits.

Claimant is entitled to an assessed attorney fee for finally prevailing 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 assessed fee for claimant's counsel's services at hearing and on review is \$1,800, to be paid by the SAIF Corporation on behalf of the noncomplying employer. In reaching this conclusion, we have particularly considered the complexity of the issue, the time devoted to the case (as represented by the

hearing record and claimant's appellate briefs) and the value of the interest involved. Moreover, we note that we have decided this matter on a legal basis not raised by claimant's counsel.

ORDER

The Referee's order dated December 23, 1991 is reversed. The noncomplying employer's denial is set aside. Claimant's left forearm injury claim is remanded to the SAIF Corporation as processing agent for the noncomplying employer. SAIF is directed to process claimant's claim in accordance with law. Claimant's counsel is awarded an assessed attorney fee of \$1,800, to be paid by SAIF on behalf of the noncomplying employer.

October 30, 1992

Cite as 44 Van Natta 2240 (1992)

In the Matter of the Compensation of
RALPH L. WITT, Claimant
WCB Case Nos. 90-22553, 90-22551, 91-00579, 90-22549, 90-22550, 90-22552, 91-00582, 91-00581, 91-05226,
91-05227, 91-08190, 90-03335, 91-08189 & 91-00580

ORDER OF ABATEMENT

Black, et al., Claimant Attorneys
Norm Cole (Saif), Defense Attorney
Snarskis, et al., Defense Attorney
Kevin Mannix, P.C., Defense Attorneys
Terrall & Associates, Defense Attorneys
Mitchell, et al., Defense Attorneys

Aetna Insurance, on behalf of Bear Creek Electric, requests abatement and reconsideration of our October 6, 1992 Order on Review. In that order, we reversed the Referee's order finding that EBI Companies was barred from denying compensability and responsibility for claimant's occupational disease claim for asbestosis and, alternatively, found EBI responsible for the condition. Our order found that a prior 1987 proceeding was limited to litigation of a pleural fibrosis condition and, therefore, the asbestosis condition was not actually litigated. Thus, we concluded that issue preclusion did not apply. Furthermore, we found that the "factual transaction" at issue in the 1987 action concerned the date that claimant was disabled from his pleural fibrosis condition and which carrier was at risk on that date whereas the "factual transaction" of the present proceeding related to claimant's disability from asbestosis. Moreover, we found that there was no opportunity in 1987 to litigate the asbestosis condition based on our finding that the diagnosis of asbestosis had not been confirmed until 1989. Therefore, we concluded that claim preclusion also did not apply.

Aetna primarily challenges our conclusion regarding claim preclusion, asserting that EBI had the opportunity to litigate the asbestosis condition and that the factual transaction is the same in the 1987 and the current proceedings.

In order to consider Aetna's motion, we withdraw our October 6, 1992 order. The remaining parties are granted an opportunity to respond by submitting responses within 14 days of this order. Thereafter, we shall take the matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANA W. WOOD, Claimant
WCB Case No. 91-12159
CORRECTED ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Kinsley, Hooton and Brazeau.

It has come to our attention that our October 30, 1992 order did not include Member Brazeau's dissenting opinion. To correct this error, we withdraw our October 30, 1992 order and issue this order in its stead. The parties' rights of appeal shall begin to run from the date of this order.

Claimant requests review of Referee Gruber's order which affirmed an Order on Reconsideration affirming a Determination Order awarding 17 percent (54.4 degrees) unscheduled permanent disability for a low back injury. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's stipulated facts and findings of fact, with the following supplementation.

We adopt the parties' stipulation that claimant's impairment is equal to 7 percent. (Tr. 2-3).

In lieu of the Referee's finding of ultimate fact, we find that claimant's unscheduled permanent disability as a result of his compensable injury is equal to 19 percent.

CONCLUSIONS OF LAW AND OPINION

At hearing, the parties stipulated, among other things, that claimant has impairment equal to 7 percent, based on 4 percent impairment for an unoperated disc lesion, and 3 percent for lost range of motion. (Tr. 2-3). The sole disputed issue at the hearing was the value to be assigned for skills and training under OAR 436-35-300(4). (Tr. 3).

The Referee accepted all the parties' stipulations, except the one relating to impairment. Specifically, the Referee gave no effect to the parties' stipulation to 4 percent impairment for an unoperated disc lesion because the stipulation appeared to be based on an incorrect interpretation of the applicable disability standards. Instead, the Referee independently rated claimant's impairment. We disagree.

It is our policy to encourage parties to resolve disputed issues without resort to litigation. This is consistent with the statutory mandate 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). The Board rules provide that parties may resolve any issue arising out of a claim closure at any time after completion of the reconsideration process under ORS 656.268. OAR 438-09-005(1). Our policy is to approve agreements reached by the parties, unless it appears that the agreement was obtained by a party's unfair advantage over another.

Here, we find no evidence of unfairness in the parties' stipulation concerning the amount of impairment to be used in calculating claimant's unscheduled permanent disability award. The parties expressed their stipulated agreement at the hearing, and neither party thereafter objected to the agreed upon impairment value. Thus, because the issue of impairment was not disputed, it was not before the Referee for resolution and did not require his decision. See Richard H. Long, 43 Van Natta 1309, 1310 (1991); Theodore W. Lincicum, 40 Van Natta 1760, 1762-63 (1988).

We have previously held that parties cannot stipulate to which standards apply in rating claimant's disability because the Referee and Board are obliged to apply the appropriate disability standards, the parties' stipulation notwithstanding. Randal L. Brown, 44 Van Natta 1726 (1992); OAR 438-10-010. We distinguish the present case, however, since the parties here did not stipulate to which standards are applicable. Rather, the parties stipulated to a particular value for impairment. Although

the Referee found that the basis for the stipulated value was not contained in the applicable disability standards, we do not interpret the parties' stipulation as an attempt to specify which standards apply. Therefore, since there is no evidence that the parties' agreement was obtained by any unfair advantage, or that either party contends that the stipulation was unfairly obtained or should be disregarded, we find no basis for disregarding the parties' agreement. Accordingly, we adopt the parties' stipulation that claimant is entitled to 7 percent impairment.

We adopt the other values found by the Referee and proceed to recalculate the extent of claimant's unscheduled permanent disability. Claimant's age/education value is 4. The adaptability value is 3. When the age/education value (4) is multiplied by the adaptability value (3), the product is 12. The impairment rating (7) is then added to that product (12), resulting in 19 percent unscheduled permanent partial disability.

ORDER

The Referee's order dated February 10, 1992 is modified. In addition to the Order on Reconsideration award of 17 percent (54.4 degrees), claimant is awarded 2 percent (6.4 degrees), for a total award of 19 percent (60.8 degrees) unscheduled permanent disability for a low back injury. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed \$3,800.

Board Member Brazeau dissenting.

Because I cannot meaningfully distinguish this case from our holding in Randal L. Brown, 44 Van Natta 1726 (1992), I respectfully dissent.

As the majority correctly notes, we have previously held that parties may not stipulate to an application of the incorrect disability rating standards. See Randal L. Brown, *supra*. Notwithstanding Brown, however, the majority has accepted the present parties' stipulation at hearing with regard to claimant's permanent impairment rating, even though that stipulation is contrary to the correct standards. The majority concludes that this case is distinguishable from Brown because the present parties "did not stipulate to which standards are applicable."

I note that in pre-hearing colloquy, the parties stipulated that claimant has 7 percent impairment "under the disability rating standards." Thus, it is true that the parties did not specify which set of standards applies. In my view, however, the fact that they referred to "the disability rating standards" at all makes this case essentially indistinguishable from Brown.

As noted in Brown, a claimant's medically stationary date determines which set of disability rating standards are applicable. As further noted, "The Referee and the Board are also required to apply [the correct standards]," notwithstanding the parties' stipulation to the contrary.

The majority opinion suggests that the present parties simply "stipulated to a particular value for impairment." I conclude, however, that because the parties specifically stated that their stipulation was being made "under the disability rating standards," they intended to reference the correct standards. Thus, I believe that the stipulation was more specific than a mere stipulation to a "particular value for impairment."

The Referee in this case noted after the hearing that the parties had stipulated to an application of the wrong standards. He, therefore, applied the correct ones in rating claimant's disability. Because I conclude that his action was consistent with Brown, *supra*, I would affirm his order.

As a postscript, I wish to make clear that I agree with the majority's policy statement favoring dispute resolution without resort to litigation. I dissent simply because I believe the majority opinion is contrary to prior case law.

In the Matter of the Compensation of
JUAN A. GARCIA, Claimant
WCB Case No. 91-15046
CORRECTED ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of that portion of Referee Mongrain's order that upheld the SAIF Corporation's denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for his first "Ultimate Findings of Fact," with the following supplementation.

Claimant experienced a symptomatic worsening of his low back condition since the May 8, 1990 Stipulated Order, the last arrangement of compensation.

Claimant's symptomatic worsening resulted in diminished earning capacity and was more than a waxing and waning of symptoms contemplated by the previous permanent disability award.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant failed to establish a compensable worsening of his low back condition. In doing so, the Referee noted a number of factors that he found to undercut Dr. Srch's opinion. We disagree.

In order to establish a compensable worsening of his unscheduled condition, claimant must show that increased symptoms or a worsened underlying condition resulted in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989); rev'd on other grounds, Lucas v. Clark, 106 Or App 687 (1991). Because claimant received a permanent disability award prior to his worsening, he bears the additional burden of establishing "that the worsening is more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award." ORS 656.273(8).

The record contains the medical reports of Dr. Campagna, claimant's treating surgeon, and Dr. Srch, claimant's treating chiropractor. Only Dr. Srch has offered an opinion as to whether claimant's low back condition has worsened. Dr. Srch has treated claimant since 1988 and notes that claimant's symptoms dramatically increased following the last arrangement of compensation. Srch opines that this increase represented a material worsening of the condition resulting from claimant's December 7, 1987 injury. (Ex. 25-1). He further opined that claimant's objective worsening was more than a normal waxing and waning of symptoms. (Id.). He attributed claimant's worsened condition to excessive scar tissue in the area of the injury. (Id.).

Dr. Srch's opinion is supported by Dr. Campagna's report, which indicates that claimant's worsened condition did not improve with chiropractic treatment as it had prior to the last arrangement of compensation. (Ex. 16).

Dr. Srch's opinion is uncontroverted. The Referee, however, did not find it persuasive. The Referee believed that the objective findings of Dr. Srch were within claimant's subjective control. The Referee also found Dr. Srch to be "an obviously sympathetic and semi-hostile physician."

Unlike the Referee, we find Dr. Srch's opinion to be persuasive. Srch has treated claimant since the time of claimant's compensable injury and is, therefore, in the best position to determine whether claimant's condition has worsened. See Jordan v. SAIF, 86 Or App 29 (1987); Givens v. SAIF, 61 Or App 490 (1983). From his opinion, we conclude that claimant has established a pathological worsening

of his low back condition. Alternatively, we conclude that claimant has established a worsening of symptoms which represents more than a waxing and waning of symptoms.

We further conclude that claimant experienced reduced earning capacity as a result of his symptomatic worsening. Claimant was not working at the time of prior award of compensation. He testified that, after the prior award, although he tried to return to work, he was able to work only an hour or two before he experienced a return of severe symptoms. (Tr. 9). Although such a finding does not presume a worsened condition (ORS 656.273(1)(a)), we also note that Dr. Campagna took claimant off work following the July 5, 1990 medical examination. (Ex. 17). Claimant's aggravation claim is compensable. See Smith v. SAIF, supra; Edward D. Lucas, supra.

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 attorney fee for claimant's counsel's services at hearing and on review concerning the aggravation issue is \$3,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the appellate briefs and the record), the complexity of the issue, the value of the interest involved and the risk that claimant's attorney's efforts would go uncompensated in this case.

ORDER

The Referee's order dated February 21, 1991 is reversed in part and affirmed in part. That portion of the Referee's order which upheld the SAIF Corporation's denial of claimant's aggravation claim is reversed. SAIF's aggravation denial is set aside and the claim is remanded to SAIF for further processing according to law. The remainder of the order is affirmed. Claimant's attorney is awarded an assessed fee of \$3,500, to be paid by SAIF, for services rendered at hearing and on review concerning the aggravation issue.

November 5, 1992

Cite as 44 Van Natta 2244 (1992)

In the Matter of the Compensation of
JOSEPH G. OVERSTREET, Claimant
WCB Case No. 91-15048
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Mongrain's order that upheld the SAIF Corporation's denial of his medical services claim for diagnostic services. On review, the issue is medical services.

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

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(2); Stanley Meyers, 43 Van Natta 2643 (1991). The Board and its Hearings Division have 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). Here, there is no contention that the CT scan of claimant's brain was not reasonable or necessary. The dispute centers on whether the CT scan is related to the compensable cervical injury. We have jurisdiction over this causation dispute.

Claimant argues that he is not asserting that his ataxia condition is compensable or related to the compensable cervical injury. Instead, he argues that the CT scan is compensable, not because it is related to the compensable injury, but because it is related to the independent medical examination (IME), which was required by SAIF. He argues that his treating neurologist sent him for the CT scan on the basis of the IME report. (Exs. 1-6, 3A). This report noted that claimant would probably require a

neurological workup regarding his ataxia, although that condition was not related to his cervical injury. (Exs. 1-6). We disagree that this relationship is sufficient to establish that the CT scan is compensable.

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); Nathan A. Stevens, 44 Van Natta 1742 (1992); Kenneth M. Simons, 41 Van Natta 378, 380 (1989); Chester L. Wing, 41 Van Natta 2433-36 (1989).

Here, there is no evidence that the CT scan was performed to determine whether there was a causal relationship between the compensable cervical injury and the noncompensable ataxia condition. Instead, the medical evidence establishes that the compensable cervical injury and the ataxia condition were never considered to be related. (Exs. 1-6, 10, 12, 13). Thus, for the above reasons and the reasons discussed by the Referee, we find that the CT scan is not compensable.

ORDER

The Referee's order dated February 20, 1992 is affirmed.

November 5, 1992

Cite as 44 Van Natta 2245 (1992)

In the Matter of the Compensation of
JOSE G. RODRIGUEZ, Claimant
WCB Case No. 91-14598
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Holtan's order that affirmed an Order on Reconsideration which awarded no unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability.

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

Claimant argues that two reports from Dr. Lewis, his attending physician, establish that he has impairment in the form of a chronic condition. We disagree.

Former OAR 436-35-320(5) provides that "[a] worker may be entitled to unscheduled chronic condition impairment where a preponderance of medical opinion establishes that the worker is unable to repetitively use a body area due to a chronic and permanent medical condition."

On May 21, 1991, Dr. Lewis examined claimant and noted no objective findings of impairment. (Ex. 14). However, he noted "tenderness over the transverse processes of L3, L4 and L5 as well as the midline sacrum." (Ex. 14-1). He also noted that claimant had "chronic lumbosacral pain" and recommended that claimant look for work with limitations of no sitting or standing for more than two hours at a time, no frequent bending or stooping, and no lifting greater than 20 pounds. (Ex. 14).

Dr. Lewis made no strictly objective findings of measurable impairment. However, we have held that "medical evidence supported by objective findings" may be based on purely objective factors, or on the worker's description of the pain that he is experiencing, as long as the physician indicates that the worker, in fact, experiences symptoms and does not merely recite the worker's complaints of pain. Suzanne Robertson, 43 Van Natta 1505 (1991).

The problem with relying solely on the May 21, 1991 report is that Dr. Lewis later explained his findings in that report. This later explanation undermines the persuasiveness of his May 1991 report as

a basis for establishing a chronic condition impairment. In a letter dated October 31, 1991, Dr. Lewis stated that he was unable to determine whether claimant's pain was real or not. (Ex. 21). Thus, Dr. Lewis did not rely on claimant's report of pain to determine that claimant suffers impairment due to the compensable injury. In addition, Dr. Lewis did not find that claimant was unable to repetitively use his lumbar spine due to a chronic and permanent medical condition. Instead, he stated that he recommended that claimant look for work which does not require repetitive use of his lumbar spine based on claimant's statements that that type of work would be more comfortable. (Ex. 21).

On this record, claimant has not established that he has any impairment as the result of his compensable lumbar injury. Therefore, he is not entitled to an award of permanent disability.

ORDER

The Referee's order dated March 10, 1992 is affirmed.

November 5, 1992

Cite as 44 Van Natta 2246 (1992)

In the Matter of the Compensation of
TIMOTHY J. SMITH, Claimant
 WCB Case No. 91-10629
 ORDER ON REVIEW
 Bischoff & Strooband, Claimant Attorneys
 Cummins, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of that portion of Referee Brown's order that increased claimant's unscheduled permanent disability award for a low back and a psychological condition from 18 percent (57.6 degrees), as awarded by Order on Reconsideration, to 56 percent (179.2 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 exception of paragraph 5 and 6 of the Referee's findings and the Referee's "Ultimate Findings of Fact." We make the following additional findings.

Dr. Vranna referred claimant to Dr. Pearson, a neuropsychologist, for evaluation of claimant's memory and other problems believed to be related to the compensable injury. Dr. Pearson found that neuropsychological testing pointed to memory impairment in both the auditory and visual modalities, particularly when there was a time lapse between exposure to information and retrieval. Dr. Pearson expected improvement of the memory problems with the passage of time. (Ex. 49).

Claimant was evaluated by Dr. Rogers Smith, a psychiatrist, as part of an independent medical examination panel. Dr. Smith found a conversion disorder "manifested by paresis of the left foot/ankle with a stocking, non-anatomic hypalgesia of the left foot to about the mid calf level." Dr. Smith tested claimant's remote and recent memory. He found that testing of recent memory showed no significant defects and his remote memory was average and demonstrated attention to significant dates within his family history and constellation. (Ex. 55). Claimant was also evaluated by Dr. Thompson, psychiatrist, in a second independent medical examination. (Ex. 69).

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).

The applicable standards are those in effect on the date of the Notice of Closure or Determination Order. 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 standards are those in effect on April 17, 1991, the date of the Determination Order. Former OAR 436-35-270 through 436-35-450 apply to the rating of claimant's unscheduled permanent disability. WCD Admin. Order 2-1991. 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.

With the exception of a medical arbiter appointed pursuant to ORS 656.268(7), "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." ORS 656.245(3)(b)(B); Dennis E. Conner, 43 Van Natta 2799 (1992). As a result, unless the attending physician concurs with or adopts such findings, the findings of an independent medical examiner may not be used to assign impairment values under the standards. Raymond D. Lindley, 44 Van Natta 1217 (1992).

Although it raised no such objection at hearing, the employer argues on review that the Order on Reconsideration is invalid because no medical arbiter was appointed. Assuming without deciding that the employer can raise such an objection, the employer seems to indicate that the dispute in this case involves the amount of impairment that should be derived from application of the standards rather than a disagreement with the attending physician's impairment findings. Under such circumstances, no medical arbiter need be appointed and the Order on Reconsideration is valid. See Doris C. Carter, 44 Van Natta 769, 770 (1992).

Impairment/Low Back

We adopt the reasoning and conclusions concerning the extent of permanent impairment of the low back as set forth in the Referee's order.

Impairment/Psychological Condition

The Referee found that claimant was entitled to 50 percent impairment for brain damage under class III of OAR 436-35-390(10) because he concluded that claimant had a permanent memory deficit. The employer argues that claimant is not entitled to an award for a psychological condition because the attending physician did not make, concur in, or adopt any findings regarding claimant's impairment due to his psychological condition. We disagree.

Claimant's attending physician, Dr. Vranna, who is not a psychologist or psychiatrist, referred claimant to neuropsychologist Pearson for evaluation of his psychological condition. Moreover, Vranna deferred to Pearson's opinion when asked about his reaction to an independent medical examiner's psychiatric report. Therefore, we find that Vranna concurred in Pearson's psychiatric evaluation of claimant. Consequently, Pearson's report may be used to evaluate claimant's psychological impairment due to brain damage.

The employer next argues that, even if Pearson's reports are relied on, they do not indicate that claimant's memory deficit is permanent. Therefore, the employer asserts, the memory condition should not be rated under the standards. We agree.

OAR 436-35-007(1) provides that a worker is entitled to a value under the rules only for those findings of impairment that are permanent and were caused by the accepted injury and/or its accepted conditions. Here, Dr. Pearson indicated that he expected that claimant's memory would improve over time. Such an opinion does not support a conclusion that claimant's memory deficit constituted permanent impairment. Inasmuch as claimant's memory impairment is not permanent, he is not entitled to an award for that condition under the standards.

Based on Dr. Pearson's findings, we conclude that claimant has minimal emotional and sleep disturbances which entitle him to an award of 10 percent impairment under Class I of OAR 436-35-390(10). The Referee's award of 12 percent for a low back condition is combined with the 10 percent for claimant's impairment due to brain damage to equal 21 percent unscheduled permanent disability. As noted by the Referee, claimant has returned to his regular work. Therefore, no values are given for age, education and adaptability.

ORDER

The Referee's order dated December 17, 1991 is modified. In lieu of the Referee's award, and in addition to the Order on Reconsideration award of 18 percent (57.6 degrees), claimant is awarded 3 percent (9.6 degrees) unscheduled permanent disability, giving him a total unscheduled disability award for a low back and psychological condition of 21 percent (67.2 degrees). The Referee's attorney fee award is modified accordingly.

November 5, 1992

Cite as 44 Van Natta 2248 (1992)

In the Matter of the Compensation of
WAYMAN D. WILKERSON, Claimant
WCB Case No. 91-03156
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Herman's order that set aside its denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation.

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

The insurer argues that it is claimant's burden to prove that his worsened condition is not due in major part to an off-the-job injury. It argues that, because claimant failed to meet that burden of proof, he failed to establish a compensable aggravation of his low back condition. We agree with the Referee that the insurer has the burden of proving its assertion that an off-the-job injury is the major contributing cause of claimant's worsening. Furthermore, we agree with the Referee that the insurer failed to meet that burden.

In Roger D. Hart, 44 Van Natta 2189 (1992), we recently decided the issue of which party has the burden of proof regarding the contribution of an off-the-job injury in an aggravation case. We found that, under ORS 656.266, claimant has the burden of proving that the compensable injury is a material contributing cause of the worsened condition. Elizabeth A. Bonar-Hanson, 43 Van Natta 2578 (1991). However, we found that if, pursuant to ORS 656.273(1), the insurer denies the aggravation claim on the grounds that an off-the-job injury is the major contributing cause of the worsened condition, as the proponent of that fact, the insurer has the burden of proving it. Roger D. Hart, *supra*.

Here, claimant carried his burden by proving that the compensable injury is a material contributing cause of the worsened condition. Under amended ORS 656.273(1), the question becomes whether the insurer carried its burden of proving its assertion that the off-the-job injury is the major contributing cause of the worsened condition. On this record, the insurer failed to carry its burden. We agree with the Referee that claimant's treating physician, Dr. McQueen, provided the only medical evidence as to causation. Dr. McQueen was unable to identify which injury was the major cause of claimant's worsened condition. Dr. McQueen opined that both injuries had "a similar major impact." (Ex. 23-26). Therefore, the insurer's denial must be set aside.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the aggravation issue is \$1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated November 5, 1991 is affirmed. For services on review, claimant's attorney is awarded a fee of \$1,000 to be paid by the insurer directly to claimant's attorney.

November 6, 1992

Cite as 44 Van Natta 2249 (1992)

In the Matter of the Compensation of
ROBERT AAGESEN, Claimant
WCB Case No. TP-92011
THIRD PARTY DISTRIBUTION ORDER
Pozzi, Wilson, et al., Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

The SAIF Corporation, as a paying agency, has petitioned the Board for resolution of a dispute concerning a "just and proper" distribution of proceeds from a settlement which arose from a legal malpractice action against claimant's attorney in a third party cause of action. ORS 656.593(3); Toole v. EBI Companies, 314 Or 102 (1992). Claimant recognizes that the Toole holding supports a conclusion that SAIF is entitled to a share of the settlement proceeds. However, claimant contends that SAIF relinquished its right to share in the recovery prior to the Toole decision. We hold that SAIF is entitled to a share of the settlement.

FINDINGS OF FACT

In August 1985, claimant sustained a compensable injury when he fell from a ladder. SAIF accepted the claim and has provided benefits.

Claimant retained legal counsel to initiate a third party cause of action against the manufacturer of the ladder. With SAIF's approval, claimant and the third party settled claimant's cause of action for \$50,000.

Thereafter, claimant asserted a legal malpractice claim against the attorney who represented him in the third party action. Claimant and the Professional Liability Fund (PLF) proposed to settle this malpractice claim for \$75,000.

SAIF sought further recovery of its lien against the malpractice settlement. Claimant objected to SAIF's contention, arguing that the malpractice recovery was not lienable.

In October 1990, claimant and SAIF agreed to resolve their dispute concerning the malpractice settlement. In return for SAIF's approval of the settlement, claimant agreed to hold approximately \$32,000 in trust pending resolution of SAIF's entitlement to a share of the \$75,000 proceeds. SAIF agreed that the funds in trust would not be disbursed "until such time as a court order or mutual agreement is determined." At the time of this agreement, the Board had issued Charlene Toole, 41 Van Natta 1392 (1989), which supported SAIF's contention that a paying agency's lien extended to the proceeds from a legal malpractice settlement.

In June 1991, claimant's attorney reminded SAIF that \$32,864.13 was being held in trust pending the court's decision in Toole. Noting that the court had recently held that a claimant's third party lien does not attach to a malpractice action, Toole v. EBI Companies, 108 Or App 87 (1991), claimant's attorney sought confirmation that SAIF's lien was not recoverable.

SAIF's legal counsel acknowledged that the Toole decision did not support its position. Nevertheless, since a petition for Supreme Court review in Toole was pending, SAIF requested that "all monies remain in your malpractice trust account until that appeal has run its course."

In October 1991, another SAIF legal counsel advised claimant's attorney that responsibility for the dispute had been assigned to that counsel. SAIF's new counsel requested the status of the funds being held in trust. Claimant's attorney responded to the status request, stating that "\$32,864.13.

continues to be held in trust, along with accrued interest, pending the outcome in Toole v. EBI Companies."

For the next 10 months, no further correspondence was submitted concerning the disputed funds. During this time, the Toole decision remained pending before the Supreme Court.

On August 17, 1992, SAIF's new counsel forwarded a letter to claimant's attorney requesting that claimant's attorney "accept my apology for not reviewing this file sooner." Noting that the Court of Appeals decision in Toole "clearly establishes that SAIF has no lien against the proceeds of the settlement effected in the above matter," SAIF's counsel authorized claimant's attorney "to disburse the sum of \$32,864.13 held in your trust account in accordance with our previous correspondence." (Emphasis added.) Finally, SAIF's counsel requested "written confirmation from you that disbursement has been made."

On August 20, 1992, the Supreme Court issued its opinion in Toole v. EBI Companies, 314 Or 102 (1992). Reversing the Court of Appeals' decision, the Supreme Court held that a third party lien does attach to a legal malpractice recovery.

On August 21, 1992, claimant's attorney responded by letter to SAIF's counsel's recent letter. Claimant's attorney was not aware of the Supreme Court's decision in Toole. In light of SAIF's concession of its lien and its authorization to disburse the funds being held in trust, claimant's attorney reported that he was distributing those funds. Claimant's attorney concluded with the following statement: "If I am incorrect in my reading of your letter, please let me know immediately."

On August 27, 1992, a third SAIF legal counsel forwarded another letter to claimant's attorney. Acknowledging their phone conversation that day, SAIF's counsel retracted the August 17th release from SAIF's prior counsel. Stating that the prior counsel was "obviously unaware" that the Toole decision was pending Supreme Court review when the disbursement release was granted, SAIF's current counsel contended that the release letter was a mistake on which claimant's attorney had not detrimentally relied.

On September 9, 1992, SAIF's prior counsel forwarded a letter to claimant's attorney. Acknowledging that he had been misinformed concerning the status of the Court of Appeals decision in Toole, SAIF's prior counsel confirmed that the August 17, 1992 release letter had been "written in error." Reasserting SAIF's entitlement to recover its share of the malpractice recovery, SAIF's prior counsel demanded the funds which had been held in trust, including interest.

When claimant's attorney did not respond to this demand, SAIF petitioned the Board for resolution of the dispute.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that SAIF relinquished its right to a share of the settlement proceeds prior to the Supreme Court's decision in Toole. In support of this contention, he relies on his counsel's October 1990 agreement with SAIF's counsel to hold the disputed funds in trust pending a "court order or mutual agreement" concerning the disbursement of funds. Asserting that SAIF's counsel's August 17, 1992 letter authorizing disbursement of those funds represents the aforementioned "mutual agreement," claimant argues that SAIF waived its right to share in the recovery. We disagree with claimant's reasoning.

A review of the parties' correspondence preceding SAIF's counsel's August 17, 1992 letter leads to the following conclusions concerning the parties' intentions. In October 1990, the parties initially agreed that the disputed funds would be held by claimant's attorney in trust pending a "court order or mutual agreement" concerning the disbursement of the funds. However, following the Court of Appeals decision in Toole, the parties agreed that the funds would remain in trust until the Toole appeal had "run its course." This understanding was further confirmed by claimant's attorney's October 30, 1991 letter in response to SAIF's counsel's status request. Specifically, claimant's attorney stated that the funds continued to be held in trust "pending outcome in Toole v. EBI Companies."

In light of these circumstances, we do not share claimant's interpretation that the parties' initial understanding that the disputed funds could be disbursed by means of "mutual agreement" remained in force at the time of SAIF's counsel's August 17, 1992 letter. Instead, the aforementioned correspondence persuasively establishes that disbursement was expressly contingent on the ultimate appellate decision in Toole.

Notwithstanding this conclusion, the parties' agreement could be modified and, in this regard, claimant could be understood to argue that SAIF's counsel's August 17, 1992 letter represents that modification. Yet, to constitute an enforceable agreement, there must be a common understanding, *i.e.*, a "meeting of minds," which did not occur here. The controlling principle is stated as follows:

"[A]n offer and an acceptance are deemed to effect a meeting of the minds, even though the offeror made a material mistake in compiling his offer, provided the acceptor was not aware of the mistake and had no reason to suspect it. But if the offeree knew of the mistake, and if it was basic, or if the circumstances were such that he, as a reasonable man, should have inferred that a basic mistake was made, a meeting of the minds does not occur." Rushlight Co. v. City of Portland, 198 Or 194, 244 (1950).

Based on the extensive amount of correspondence preceding SAIF's counsel's August 17, 1992 letter, it is clear that the authorization was provided in error. In other words, contrary to SAIF's counsel's understanding, the Toole appeal had not "run its course." It is likewise clear that claimant's attorney suspected a mistake. In acknowledging the August 17, 1992 letter, he stated: "If I am incorrect in my reading of your letter, please let me know immediately." Since SAIF's counsel had expressly authorized claimant's attorney to disburse the funds and merely requested a written confirmation of that disbursement, we consider the inclusion of the aforementioned sentence to be significant.

Consequently, we conclude that SAIF's counsel's August 17, 1992 letter had no effect on the parties' agreement that disbursement was expressly contingent on the ultimate appellate decision in Toole. Because SAIF's counsel promptly retracted the authorization on receipt of claimant's attorney's request for confirmation of that authorization, we hold that SAIF did not waive its right to recover the disputed funds. Accordingly, claimant's attorney is directed to forward the disputed funds to SAIF as its "just and proper" share of the proceeds from the legal malpractice settlement. ORS 656.593(3); Toole v. EBI Companies, *supra*.

IT IS SO ORDERED.

November 6, 1992

Cite as 44 Van Natta 2251 (1992)

In the Matter of the Compensation of
MARY A. ASANOVIC, Claimant
 WCB Case No. 91-13017
 ORDER ON REVIEW
 Pozzi, et al., Claimant Attorneys
 James Dodge (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

The SAIF Corporation requests review of Referee Bethlahmy's order that: (1) awarded claimant 36 percent (54 degrees) scheduled permanent disability for loss of use or function of her left leg, whereas an Order on Reconsideration affirmed a Determination Order award of 29 percent (43.5 degrees) scheduled permanent disability for her left leg; and (2) directed SAIF 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 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 scheduled permanent disability

On review, SAIF disagrees only with that portion of the Referee's order which found that claimant was entitled to an award of 10 percent for mild knee joint instability. Former OAR 436-35-230(3) provides that for knee joint instability, 10 percent may be awarded where the joint opening is 2 millimeters in more than one plane or 3 millimeters in one plane.

SAIF argues that claimant's treating doctor could not have made an objective finding to support an award as there is no evidence that he used an x-ray or MRI or mechanical testing to obtain such a measurement. SAIF argues that the Lachman maneuver used by Dr. Neitling cannot produce the type of measurement required by former OAR 436-35-230(3).

We agree with the Referee that claimant has established entitlement to an award pursuant to former OAR 436-35-230(3). Although SAIF disagrees with Dr. Neitling's conclusions regarding claimant's knee joint instability, it has produced no medical evidence that Dr. Neitling's tests cannot be used to accurately measure such impairment. Under the circumstances, we defer to the un rebutted opinion of claimant's treating physician and we affirm the Referee's award of 10 percent for mild knee joint instability.

Consequently, we affirm the Referee's award of 36 percent scheduled permanent impairment for claimant's loss of use or function of the left leg.

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).

Claimant is entitled to an assessed attorney fee for successfully defending against SAIF's request for a reduction of her scheduled permanent disability award. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services on the issue of extent of disability is \$500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the complexity of the issue, the time devoted to the issue (as represented by the portion of claimant's respondent's brief devoted to the extent issue) and the value of the interest involved.

ORDER

The Referee's order dated January 16, 1992 is reversed in part and affirmed in part. Those portions of the Referee's order that directed the SAIF Corporation to pay claimant's scheduled permanent disability at the rate of \$305 per degree and awarded an attorney fee based on this increased compensation are reversed. SAIF 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. For prevailing against SAIF's request for review on the issue of extent of scheduled permanent disability, claimant's counsel is entitled to an assessed attorney fee award of \$500, to be paid by SAIF.

In the Matter of the Compensation of
JOHN E. BECK, Claimant
WCB Case No. 91-12288
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of that portion of Referee Brown's order that increased claimant's unscheduled permanent disability award for a cervical, lumbar, and left shoulder injury from 8 percent (25.6 degrees), as awarded by a Determination Order and affirmed by an Order on Reconsideration, to 17 percent (54.4 degrees). On review, the issue is extent of unscheduled permanent disability.

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

The Referee relied upon the report of Dr. Colletti, orthopedic surgeon, to award claimant 17 percent unscheduled permanent disability. SAIF asserts that the Referee incorrectly construed Dr. Colletti's report. Specifically, SAIF contends that Dr. Colletti found that the range of motion findings were due to functional impairment or a degenerative condition rather than the industrial injury. Therefore, SAIF maintains that such findings could not be the basis for the unscheduled permanent disability award.

We disagree. Dr. Colletti did state that claimant "has a completely nonanatomic pattern of sensory loss in his entire upper extremity associated with a number of other functional findings, which suggest a nonorganic element to some of his complaints." (Ex. 13-5). This statement, however, was made in the context of discussing sensory loss, not range of motion. We find no suggestion in the report that Dr. Colletti found the range of motion findings questionable or due to a degenerative condition. Therefore, we conclude that the report was reliable.

Because SAIF raises no other challenges to the Referee's order, we affirm it.

Claimant's attorney is entitled to an assessed 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 conclude that a reasonable fee is \$700, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 17, 1992, as amended May 5, 1992, is affirmed. For services on review, claimant's attorney is awarded an assessed fee of \$700, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
SHERI L. CODY, Claimant
WCB Case No. TP-92013
THIRD PARTY DISTRIBUTION ORDER
Vogt & Associates, Claimant Attorneys
Charles Lundeen, Defense Attorney

Liberty Northwest Insurance Corporation (Liberty), as paying agency, has petitioned the Board for resolution of a conflict concerning the "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, the dispute pertains to the amount of Liberty's share of the settlement proceeds. We conclude that a distribution in accordance with ORS 656.593(1) is "just and proper."

FINDINGS OF FACT

In March 1990, claimant sustained a compensable low back injury when she slipped and fell while performing her work activities for a medical laboratory. Liberty accepted the claim and has provided compensation. To date, it has incurred actual claim costs totalling \$2,100.72.

Claimant retained legal counsel to pursue a third party lawsuit against the building maintenance company for the medical laboratory. Following an arbitration hearing, claimant and the third party reached an \$8,500 settlement. Liberty approved the settlement on the condition that its entire \$2,100.72 lien be paid in full. Claimant's attorney accepted this condition informing Liberty that its \$2,100.72 lien would be "paid in full in the amount of \$2,100.72 upon negotiation of the settlement check."

Thereafter, Liberty received a check from claimant's attorney in the amount of \$1,400.48. Noting that one-third had been deducted from Liberty's \$2,100.72 lien (for a "standard attorney fee"), claimant's attorney asserted that the check was "payment in full of [Liberty's] claim."

Liberty returned the check to claimant's attorney. Contending that claimant's attorney was not entitled to reduce its lien by an attorney fee, Liberty requested full payment of its lien. When no payment was forthcoming, Liberty petitioned the Board for resolution of the dispute.

A distribution of the third party settlement in accordance with ORS 656.593(1) is "just and proper." Such a distribution would permit Liberty to receive \$2,100.72 as full reimbursement for its lien.

CONCLUSIONS OF LAW

If a worker receives a compensable injury due to the negligence or wrong of a third party not in the same employ, the worker shall elect whether to recover damages from the third person. ORS 656.578. The proceeds of any damages recovered from the third person by the worker shall be subject to a lien of the paying agency for its share of the proceeds. ORS 656.593(1). "Paying agency" means the self-insured employer or insurer paying benefits to the worker or beneficiaries. ORS 656.576.

Here, claimant sustained a compensable injury as a result of the negligence or wrong of a third person. The claim was accepted by Liberty, who has provided compensation. Inasmuch as Liberty has paid benefits to claimant as a result of a compensable injury, it is a paying agency. ORS 656.576. As such, it is entitled to its statutory share of the third party recovery. ORS 656.593(1).

When claimant chose to seek recovery from the third party, the provisions of ORS 656.580(2) and 656.593(1) became applicable. Thus, the third party settlement became subject to Liberty's lien for its "just and proper" share. See ORS 656.593(3). We now proceed to a determination of a "just and proper" distribution.

The statutory formula for distribution of a third party recovery obtained by judgment, ORS 656.593(1), is generally applicable to the distribution of a third party recovery obtained by settlement. Robert L. Cavil, 39 Van Natta 721 (1987). We take such an approach to avoid making "equitable distributions on an ad hoc basis and to permit the parties to generally know where they stand as they seek to settle a third party action." See Marvin Thornton, 34 Van Natta 999, 1002 (1982).

We find no persuasive reason to depart from the aforementioned approach. Therefore, after the deduction of attorney fees, litigation costs, and claimant's statutory 1/3 share, Liberty is entitled to retain the balance of the third party recovery to the extent that it is compensated for its expenditures for compensation, first aid or other medical, surgical or hospital service, and for the present value of its reasonably expected future expenditures for compensation and other costs of the worker's claims under ORS 656.001 to 656.794. See ORS 656.593(1)(a), (b), and (c).

Claimant has not contested Liberty's assertion that it has incurred \$2,100.72 in actual claim costs. Under such circumstances, we conclude that Liberty's "just and proper" share of the third party settlement is \$2,100.72.

Rather than distributing \$2,100.72 to Liberty in full satisfaction of its lien, claimant's counsel deducted one-third of the lien for a "standard attorney fee." Claimant's counsel's justification for this unilateral action is that claimant is under no obligation to recover Liberty's share of the settlement free of charge. Yet, there is no statutory provision that would permit claimant's attorney to reduce the recovery of Liberty's lien by an additional attorney fee. See Clifford S. Brush, 44 Van Natta 954, 955 (1992). (Claimant's attorney not entitled to reduce a paying agency's share of a third party recovery for an additional attorney fee.) Instead, the statutory distribution scheme is precise.

Specifically, pursuant to ORS 656.593(1)(a), a claimant's attorney fees in a third party recovery are initially deducted from the recovery and distributed to the attorney. Following this attorney fee distribution and litigation costs the remaining balance of the third party recovery is distributed amongst claimant (1/3 share) and the paying agency (to the extent of its lien). Thus, the third party statutes do not provide authorization for an additional attorney fee award other than that disbursed from a third party recovery. See Theresa J. Lester, 43 Van Natta 338 (1991).

Finally, claimant's attorney asserts that she was operating under a "mistake of fact" that full satisfaction of Liberty's lien was required before a settlement could be achieved. We find this contention unpersuasive. To begin, any mistake made by claimant's attorney was one of law in that the third party statutes expressly recite each party's rights and obligations regarding third party recoveries. Moreover, had claimant sought Board resolution of Liberty's entitlement to recovery of its entire lien in conjunction with a determination concerning the reasonableness of the settlement, we would have continued to follow the statutory distribution scheme. See Robert L. Cavil, *supra*. Thus, regardless of when claimant challenged Liberty's share of the third party settlement proceeds, we would reach the same decision.

In conclusion, claimant's counsel's unilateral action was clearly contrary to the statutory distribution scheme as set forth in ORS 656.593(1) and (3). As a result of claimant's counsel's impermissible distribution, Liberty's recovery has been invalidly reduced. Under such circumstances, we have previously held that the paying agency may recover its unpaid lien from either claimant or her attorney. Steven B. Lubitz, 40 Van Natta 450 (1988).

In accordance with the reasoning discussed above and the rationale articulated in the Lubitz holding, we conclude that claimant's attorney is jointly and severally responsible for remedying this situation. Accordingly, claimant and/or claimant's attorney are directed to pay Liberty its rightful share of the settlement proceeds. i.e, \$2,100.72.

IT IS SO ORDERED.

In the Matter of the Compensation of
THOMAS E. GLOVER, Claimant
WCB Case No. 91-15215
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Mongrain's order that set aside its denial of claimant's claim for a left distal tibula amputation. 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 claimant credible based on his demeanor while testifying. We defer to that finding, because of the Referee's opportunity to observe the witness. Humphrey v. SAIF, 58 Or App 360 (1982). Relying on claimant's testimony and the medical evidence, the Referee concluded that claimant had established a compensable claim. After our review of the record, we agree and adopt the Referee's conclusions and reasoning. We add the following supplementation.

On review, the insurer argues that the Referee erred in applying the material contributing cause test to determine whether the claim is compensable. Asserting that claimant's left foot laceration combined with his preexisting diabetes and peripheral neuropathy to necessitate the amputation of his left foot, the insurer contends that claimant should have been required to meet the major contributing cause standard for a resultant condition under ORS 656.005(7)(a)(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."

We considered that provision in Bahman M. Nazari, 44 Van Natta 831 (1992), where we held that a worker who suffers a compensable injury, yet who also suffers from a preexisting condition that combines to cause disability or a need for treatment, will be compensated only if the compensable injury is the major contributing cause of that disability or need for particular treatment. We conclude, however, that ORS 656.005(7)(a)(B) is inapplicable here, because there is no persuasive medical evidence in the record that claimant's preexisting diabetes combined with the foot laceration to require the amputation. See Janice M. Broderick, 43 Van Natta 1931 (1991). Drs. Haynes and Black, who treated claimant upon his return to Oregon, opined that the amputation was the direct result of the foot laceration and infection. Dr. Theen, who examined claimant at the insurer's request, noted that claimant might have suffered fewer complications without the diabetic neuropathy. He concluded, however, that there would have been no need for amputation without the trauma to the foot that occurred on the job.

On this record, we conclude that claimant is seeking compensation for disability and need for treatment that is caused by an industrial accident. Accordingly, claimant is only required to prove that the injury was a material contributing cause of that disability and treatment. The insurer's denial must be set aside.

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 February 13, 1992 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of \$1,000, to be paid by the insurer.

November 6, 1992

Cite as 44 Van Natta 2257 (1992)

In the Matter of the Compensation of
NANCY C. GOFF, Claimant
WCB Case No. 90-08877
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of those portions of Referee Hazelett's order that: (1) affirmed claimant's scheduled permanent disability of 34 percent (51 degrees) for loss of use or function of her right knee, as awarded by an Order on Reconsideration; and (2) directed it 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 affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINIONExtent of Scheduled Permanent Disability

SAIF asserts that claimant was overcompensated by the Order on Reconsideration because claimant's treating physician, Dr. Bert, orthopedist, indicated no lost range of motion in claimant's right knee.

SAIF relies upon Dr. Bert's July 3, 1991 chart note stating "[f]ull range of motion of [claimant's] knee on the right." (Ex. 19-2). An earlier note, however, found "[g]ood range of motion of her now. I would say full flexion to 140 degrees." (Id. at 1). At that time, Dr. Bert also declared claimant medically stationary. (Id.) We conclude that, because Dr. Bert earlier referred to "full flexion" as 140 degrees and he declared claimant medically stationary on that date, the most reasonable construction of his July 3, 1991 note was that claimant exhibited flexion to 140 degrees on that date. Therefore, we agree with the Referee that claimant is entitled to a rating for lost range of motion.

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 fee for prevailing against SAIF's request for review regarding the extent issue. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee is \$500, to be paid by SAIF. 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 April 2, 1992 is affirmed in part and reversed in part. Those portions of the order directing SAIF to pay claimant's scheduled permanent disability award at the rate of \$305, and awarding an out-of-compensation attorney fee payable from this increased compensation, are reversed. Claimant is entitled to be paid scheduled permanent disability compensation at the rate in effect at the time of the compensable injury. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of \$500, to be paid by the SAIF Corporation.

November 6, 1992

Cite as 44 Van Natta 2258 (1992)

In the Matter of the Compensation of
LISA A. HYMAN, Claimant
WCB Case No. 91-03726
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerland.

Claimant requests review of that portion of Referee Hoguet's order that declined to award claimant's counsel an assessed attorney fee under ORS 656.386(1) for allegedly prevailing over a "de facto" denial of medical services. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings with the exception of the Referee's second ultimate finding of fact. In addition, we make the following findings.

On January 16, 1991, SAIF denied claimant's claim for an aggravation of her low back condition. (Ex. 29). When the hearing in this matter initially convened on November 18, 1991, claimant raised the issue of a "de facto" denial of medical treatment. (Tr. 2). In its opening statement, SAIF argued that it had denied an aggravation only and that the evidence would show that it had paid the medical bills. (Tr. 4). After the hearing, the record was left open at the request of the Referee and with the agreement of the parties, so that the parties could examine the claim file and reach an agreement regarding whether any medical bills or time loss was owing on the claim. (Tr. 17).

In response to the Referee's request, SAIF acknowledged by letter dated December 9, 1991 that it had not paid 15 medical bills totalling \$3,267.23 which it received between November 26, 1990 and September 9, 1991. (Ex. 36-1). In the same letter, SAIF also acknowledged that it owed claimant an additional \$45.90 for prescription and mileage reimbursements. The parties agreed that SAIF would pay the 15 medical bills and the mileage and prescription reimbursements and would also pay a 25 percent penalty on the total amount. (Ex. 37). Upon receipt of the parties' agreement, the record was closed on January 23, 1992.

FINDINGS OF ULTIMATE FACT

The medical bills were not accepted or denied within 90 days.

The late payment of medical bills constitutes a "de facto" denial of the claim.

Claimant's attorney is entitled to an assessed attorney fee pursuant to ORS 656.386(1) for prevailing over SAIF's "de facto" denial of medical services.

CONCLUSIONS OF LAW AND OPINION

The Referee found there was no "de facto" denial of medical services and declined to award an attorney fee pursuant to ORS 656.386(1) for prevailing over such a denial. We disagree.

In its brief, SAIF argues that it did not "de facto" deny the claim because it did not intend to deny the bills and, therefore, it did not deny compensation but merely paid it unreasonably late. We do not find SAIF's argument persuasive. The legal test for whether a "de facto" denial has occurred is not whether the self-insured employer or insurer intends to deny the claim. Rather, the test is whether or not the claim has been accepted or denied within the 90 day period allowed by statute. ORS 656.262(6); Barr v. EBI Companies, 88 Or App 132, 134 (1987); Doris J. Hornbeck, 43 Van Natta 2397 (1991).

Here, SAIF conceded that the medical bills at issue were not paid within 90 days and it agreed to pay a penalty on those late bills. Under such circumstances, the medical services were denied "de facto." See Deborah K. Atchley, 44 Van Natta 1435 (1992).

Because claimant prevailed finally over SAIF's "de facto" denial of medical services, we find that claimant's attorney is entitled to an 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 concerning the "de facto" denial is \$1,500, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by appellant's brief, statement of services and the hearing record), the complexity of the issue, and the value of the interest involved.

In reaching our decision, we note that the oldest of the unpaid medical bills at issue was received by SAIF on November 26, 1990, less than 90 days before claimant's February 14, 1991 hearing request. Therefore, claimant's hearing request was apparently premature with respect to the issue of a "de facto" denial of medical services. A premature request for hearing is ineffective and void. Syphers v. K-W Logging, Inc., 51 Or App 769 (1981); Michael A. Dipolito, 44 Van Natta 981 (1992).

However, here, SAIF acknowledged that it paid the medical bills late thereby admitting that it had eventually "de facto" denied the claim. (Exs. 36; 37). Thus, even if claimant's hearing request on the "de facto" denial issue was premature, that infirmity was cured at hearing by SAIF's admission that it paid the bills late. See OAR 438-06-031 (new issues may be raised during the hearing, if supported by the evidence); Deborah K. Atchley, *supra*.

ORDER

The Referee's order dated March 9, 1991 is reversed in part and affirmed in part. That portion of the Referee's order that declined to award claimant an attorney fee pursuant to ORS 656.386(1) for prevailing over a "de facto" denial of medical services is reversed. For services concerning the "de facto" denial, claimant's attorney is awarded \$1,500 payable by SAIF. The remainder of the order is affirmed.

In the Matter of the Compensation of
PATRICIA J. MAYO, Claimant
WCB Case No. 91-01935
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Gunn and Brazeau.

Claimant requests review of Referee Livesley's order that: (1) dismissed claimant's request for hearing as untimely filed; (2) deferred ruling on her request to depose Dr. Hodgson; and (3) did not address the merits of the SAIF Corporation's denial of her injury claim for a vestibular condition. In her brief, claimant renews her objection to the admission of Exhibit A as untimely disclosed and requests remand with instructions to allow Hodgson's deposition and additional rebuttal evidence. On review, the issues are timeliness, compensability, remand, evidence and penalties. We deny the motion to remand, reinstate claimant's hearing request and set aside SAIF's denial.

FINDINGS OF FACT

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

The Referee found that claimant's preexisting vestibular condition cleared with treatment and bedrest by 1990. Instead, we find that an October 24, 1990 head injury at work worsened claimant's preexisting vestibular condition.

In April 1991, Dr. Hodgson, independent examiner, opined that, based on claimant's "clinical picture," her October 1990 head injury at work was "the material contributing cause to her recurrent balance complaints." (Ex. 30A-2). On May 7, 1991, the day before hearing, in a letter to SAIF's counsel, Hodgson reversed his opinion concerning causation. (See Ex. 32).

At hearing, claimant requested permission to cross-examine Hodgson and to submit additional rebuttal evidence from Dr. Grimm, treating physician. The Referee initially stated that he would allow the cross-examination of Hodgson, but deferred ruling on claimant's request for further rebuttal, pending the "outcome of the testimony." (Tr. 2). However, at the close of the hearing, the Referee denied claimant's motion to continue the hearing, for the purpose of submitting rebuttal evidence. (Tr. 163-166). Furthermore, in his order dismissing claimant's hearing request as untimely, the Referee stated, "Should the Board disagree with the referee's order and remand, leave to depose Dr. Hodgson will be granted at that juncture. But for such deposition, the evidentiary record remains frozen as of the date of hearing." (Opinion and Order p. 1).

FINDINGS OF ULTIMATE FACT

Claimant had good cause for filing her request for hearing 100 days after SAIF's denial of her head injury claim.

Claimant's October 24, 1990 work injury was the major contributing cause of her subsequent disability and need for treatment for a worsened inner ear condition.

SAIF's denial was reasonable under the attendant circumstances.

CONCLUSIONS OF LAW AND OPINION

Timeliness/good cause

The Referee dismissed claimant's request for hearing because he found that claimant's physical and mental conditions did not excuse her late filing of a request for hearing. We disagree.

A hearing request must be filed within 60 days after claimant is notified of a denial. ORS 656.319(1)(a). A request filed after 60 days but within 180 days after notification of denial is valid if claimant establishes that she had good cause for failure to file within 60 days. ORS 656.319(1)(b). Claimant bears the burden of establishing good cause for untimely filing. Hempel v. SAIF, 100 Or App 68 (1990). The test for determining if good cause exists has been equated with the standard of "mistake, inadvertence, surprise or excusable neglect" recognized under ORCP 71B(1) and former ORS 18.160. Anderson v. Publishers Paper Co., 78 OR App 513, 517, rev den 301 Or 666 (1986); see also Brown v. EBI Companies, 289 Or 455 (1980). Lack of diligence does not constitute good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985).

Here, it is undisputed that claimant's request for hearing was filed more than 60 days but less than 180 days following notice of the denial. Thus, the delay in filing may be excused if claimant had good cause for late filing. See ORS 656.319(1)(b). Notwithstanding the good cause excuse for late filing, the time limitation may be tolled under limited circumstances for periods when a claimant lacks mental competency. See ORS 656.319(2)&(3).

In this case, claimant filed a claim for a head injury on October 30, 1990, alleging that a length of plastic pipe struck her on the head at work on October 24, 1990. (See Ex. 11). SAIF denied the claim on November 7, 1990.

Claimant was hospitalized on November 8, 1990, complaining of traumatic inner ear problems. (See Exs. 12B, 13, 14). By November 9, 1990, she developed severe abdominal pain, accompanied by nausea and vomiting. (See Ex. 12B-5). She had difficulty breathing and spent some time in the Intensive Care unit with diagnoses of severe pancreatitis with sequestration of fluid and shock. (Exs. 14, 14B). Claimant treated with Demerol and morphine, among other medications.

On November 15 and 16, 1990, claimant had fluid removed from each lung. (Exs. 13-5, 13K). She was discharged from the hospital on November 20, 1991, with treatment plans to be deferred for about six weeks to allow resolution of swelling and edema. (Ex. 14). Three days later, claimant sought treatment and Dr. Massey recommended gall bladder removal. (Ex. 14B-2).

On November 23, 1990, claimant learned that her job was terminated. On November 24, 1990, she was again admitted to the hospital, suffering from an acute psychotic breakdown. (Ex. 15). She had not slept in over a month. Upon admittance, claimant was physically restrained, placed in lockup in the psychiatric ward and treated with intravenous Haldol and Valium. (Exs. 15, 16C). Suicide precautions were taken and claimant was confined to her hospital room. (Ex. 16C). Dr. Massey, consulting physician, observed that claimant was not oriented to place or person and diagnosed acute psychosis superimposed on chronic physical problems. (Ex. 16). Four days later, claimant underwent a laparoscopy and cholecystectomy. (Ex. 18). Dr. Holland, psychiatrist, later observed: "The operative findings were indeed dramatic. There was evidence in the peritoneal cavity of significant, extensive, and widespread pathology." (Ex. 30B-6).

Claimant's recovery was complicated by the need for a second right thoracentesis on December 14, 1990. She remained hospitalized, still suffering from "massive" pancreatitis, which had been "going on for approximately six weeks." (Ex. 23a-1; see Ex. 18-1). Claimant went home for a few hours on Christmas Eve and Christmas Day. However, she was otherwise hospitalized for the above-described problems from November 24, 1990 until January 4, 1991. (See Ex. 24a-1).

After claimant was released from the hospital, she remained on a feeding tube for a week and continued to treat with Valium and Demerol. (Ex. 25). By the end of January, 1991, she was feeding herself and all her tubes had been removed. She was able to sleep. (Ex. 25). On January 31, 1991, claimant sought treatment for potentially serious vaginal problems. This treatment was deferred previously, due to the pancreatitis and its complications.

On February 15, 1991, the 100th day after SAIF's denial, claimant requested a hearing through her attorney.

The Referee found the facts of this case distinguishable from those in Jerry M. McClung, 42 Van Natta 400 (1990), wherein we held that claimant's medication and physical/mental condition supported a

finding of "excusable neglect" and "good cause" sufficient to excuse his late filing. Jerry M. McClung, supra at 403. We are persuaded, however, that the present claimant's multiple medical problems do constitute "excusable neglect" and "good cause" within the meaning of ORS 656.319(1)(b).

In reaching this conclusion, we note that claimant was admitted to the hospital before she received actual notice of the denial and was not released thereafter, for more than short periods of time, until January 4, 1991, 55 days after the denial issued. While hospitalized, claimant underwent 4 surgical procedures, spent time in intensive care and psychiatric lockup and was treated with morphine, Haldol, Demerol and Valium. When she was finally released from the hospital on January 4, 1991, she wore feeding tubes and continued to take Demerol and Valium for at least a week. Considering the nature and seriousness of claimant's medical problems, her invasive course of treatment during the critical time period following SAIF's denial and the fact that these events were beyond claimant's control, we are persuaded that claimant's failure to timely request a hearing constitutes "excusable neglect." See Anderson v. Publishers Paper Co., supra.

Finally, we note Dr. Grimm's May 1991 opinion that claimant's cholecystitis and pancreatitis made her very ill and "unable to deal with her affairs for many weeks." (Ex. 31). Under these extreme circumstances, claimant has established good cause for failing to request a hearing within the 60-day time limitation. See ORS 656.319(1)(b). Accordingly, claimant's request for hearing is reinstated. Because we find the record to be sufficiently developed, we proceed to the merits.

Compensability

In Bahman M. Nazari, 43 Van Natta 2368 (1991), we held that, in cases involving preexisting conditions, the compensability of a claim involves a two-part test. 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. 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).

In this case, the expert evidence concerning causation comes from Drs. Grimm and Hodgson, neuro-otologists, treating physician and independent examiner, respectively. Dr. Grimm treated claimant in the mid-1970's for headaches and in 1988 for post-traumatic vestibular problems. Claimant sought treatment from Grimm again when her vestibular symptoms returned following the October 1990 work incident. Grimm related claimant's worsened inner ear condition to the October 24, 1990 head-strike injury at work. (Ex. 31).

Hodgson examined claimant on April 22, 1991 and initially agreed that claimant's vestibular complaints resulted from that injury. (Ex. 30A). However, after reviewing the results of vestibular tests, Hodgson reversed his opinion on May 7, 1991, the day before hearing. Notwithstanding Hodgson's opinion reversal, we find no persuasive reason not to defer to the opinion of Dr. Grimm as treating physician. See Weiland v. SAIF, 64 Or App 810 (1983). Accordingly, based on Grimm's opinion, we conclude that claimant's October 24, 1990 work injury was a material cause of her subsequent disability and need for treatment for vestibular problems. See ORS 656.005(7)(a).

Claimant's medical history reveals that she has suffered prior vestibular problems. (See Exs. 2, 30A). Although these problems had largely resolved by 1990, (see Exs. 12B-1 & 31), the medical evidence further indicates that claimant's preexisting vestibular condition "aggravated" following the October 1990 injury. (Ex. 31). Under these circumstances, we address the issue of whether claimant's "resultant condition," is compensable under ORS 656.005(7)(a)(B). Thus, claimant bears the additional burden of establishing that her work injury is the major contributing cause of her current resultant condition. See Bahman M. Nazari, supra. As we have stated, we find Grimm's opinion concerning causation to be persuasive and we rely on it. Further, in the absence of contributing causes other than the injury, we conclude that claimant has proven that her work injury is the major contributing cause of

her worsened vestibular condition. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). Consequently, the claim is compensable. See ORS 656.005(7)(a)(B).

Evidence/Remand

Claimant contends that the Referee unfairly failed to allow cross-examination and rebuttal evidence in response to Hodgson's May 7, 1991 report. He requests remand for admission of this rebuttal evidence. In addition, claimant contests the Referee's admission of Exhibit A, SAIF's record of a telephone conversation between SAIF's representative and claimant's husband. In light of our conclusions that the hearing request is reinstated and that claimant's claim is compensable, we decline to address these rulings and deny the motion to remand.

Nevertheless, we wish to emphasize that a Referee should rule on evidentiary motions as they arise and not defer such decisions pending possible "remand" from the Board. Moreover, in cases such as this, where a hearing on the merits of the claim has been held, the Referee should include an alternative conclusion addressing the compensability issue.

Penalties and attorney fees

Claimant requests a penalty for SAIF's allegedly unreasonable denial.

Penalties may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10). In determining whether a denial is unreasonable, the question is whether the insurer had a legitimate doubt as to its liability. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988). The reasonableness of a carrier's denial must be gauged based upon the information available to the carrier at the time of its denial. Brown v. Argonaut Insurance Company, supra; Price v. SAIF, 73 Or App 123, 126 n. 3 (1985). Where the carrier has a legitimate doubt as to its liability and issues a denial based on that doubt, its denial is not unreasonable. Brown, supra.

In this case, SAIF's denial is based on lack of evidence that the claim is work related and the fact that claimant had not sought medical treatment as of November 7, 1990, the date of the denial. (Ex. 12).

Considering claimant's history of traumatic inner ear problems and SAIF's awareness of this history, (see Ex. 11), we find that the denial was based on legitimate doubt regarding liability for a problem which apparently preexisted the claimed injury. Accordingly, we conclude that the denial was not unreasonable and no penalty is assessed.

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 \$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 and the hearing record), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated June 6, 1991, as reconsidered November 26, 1991, is reversed. Claimant's request for hearing is reinstated and the SAIF Corporation's denial is set aside. This claim is remanded to SAIF for further processing according to law. For his services at hearing and on review, claimant's attorney is awarded an assessed fee of \$4,000, payable by SAIF.

In the Matter of the Compensation of
LORETTA J. O'ROURKE, Claimant
WCB Case Nos. 91-18453 & 91-16786
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Steve Cotton (Saif), Defense Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Moller and Neidig.

Liberty Northwest Insurance Corporation, on behalf of Perfect Look Hair, requests review and the SAIF Corporation, on behalf of the Hair Hutch, cross-requests review of Referee Myers' order that: (1) set aside their denials of claimant's occupational disease claim for a bilateral upper extremity condition; (2) found the carriers to be jointly responsible; and (3) held that apportionment of benefits between the carriers is within the authority of the Director. Claimant cross-requests review of that portion of the order that found Liberty and SAIF jointly responsible for her condition, rather than finding Liberty solely responsible. In the alternative, claimant asks that the Board apportion 75 percent responsibility to Liberty, or order "such apportionment" by the Director. On review, the issues are compensability, responsibility, and apportionment. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's repetitive work activities as a beautician while simultaneously employed by Liberty and SAIF's insureds were the major contributing cause of her bilateral upper extremity condition. Accordingly, he found claimant's occupational disease claim compensable, and the insurers jointly responsible. The Referee did not "apportion" responsibility between Liberty and SAIF. Rather, he found both insurers responsible and directed them to petition the Director for apportionment in accordance with the administrative rules. We agree with and adopt the Referee's reasonings and conclusion. In addition, we offer the following comments.

On review, Liberty argues that claimant's occupational disease claim is not compensable. In support of its contention, Liberty relies on independent examiner Dr. Jewell's comment that he could "not state within reasonable medical probability that the claimant's work activities at Perfect Look is [sic] the major cause of her problems." That, however, is not the criterion for determining compensability where, as here, a worker was exposed to conditions which contributed to her occupational disease in two separate but simultaneous employments. Instead, claimant need only prove that her concurrent employment constituted an exposure which contributed to her occupational disease. Colwell v. Trotman, 47 Or App 855 (1980).

SAIF argues that Liberty is "totally" responsible for the claim. It contends that because claimant worked for Liberty's insured 75 percent of the time, that work constitutes the major contributing cause of her occupational disease. That analysis is flawed. Claimant's simultaneous employment by SAIF's insured also constituted an exposure which contributed to her occupational disease. Therefore, the insurers are jointly responsible for claimant's occupational disease claim. Id.

SAIF asserts that apportionment is not within the authority of the Director, lacking an arbitration proceeding. The hearing in this case convened and closed on February 10, 1992, and the order issued on February 18, 1992. OAR 436-60-195 (WCD Admin. Order 1-1992, effective February 1, 1992) provides a procedure whereby the Director of the Department of Insurance and Finance "may order monetary adjustment between insurers [in other than .307/arbitration cases], to ensure the claimant properly receives all compensation due under the workers' compensation law." The Referee did not err.

Finally, we decline claimant's invitation to apportion 75 percent responsibility to Liberty, or order "such apportionment" by the Director. Apportionment is within the Director's jurisdiction. This

Board will neither presume to perform this task nor instruct the Director in the performance of his administrative duties.

Claimant did not prevail on her cross-request for review. Consequently, she is not entitled to an attorney fee for her services on review concerning those efforts. Nevertheless, claimant's attorney is entitled to a reasonable assessed fee for services on review defending against Liberty's and SAIF's requests 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 assessed attorney fee for claimant's counsel's services on review concerning the insurer's appeals is \$500, to be paid in equal \$250 shares by Liberty and SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 18, 1992 is affirmed. For services on review concerning the insurer's appeals, claimant's counsel is awarded a reasonable attorney fee of \$500, payable by Liberty Northwest Insurance Corporation and the SAIF Corporation in equal \$250 shares.

November 6, 1992

Cite as 44 Van Natta 2265 (1992)

In the Matter of the Compensation of
CRAIG D. SMITH, Claimant
WCB Case No. 91-07818
ORDER ON REVIEW
Bottini, et al., Claimant Attorneys
Jerome Larkin (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

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

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" with the following supplementation. Claimant's compensable low back condition has worsened since the last award or arrangement of compensation. (A February 1991 Determination Order).

CONCLUSIONS OF LAW AND OPINION

The Referee upheld SAIF's denial of claimant's aggravation claim. Although the Referee concluded that claimant's low back condition had symptomatically worsened, the Referee found that such symptoms were contemplated by claimant's prior award. Consequently, the Referee reasoned that claimant's current low back condition did not constitute a compensable worsening. We disagree.

To establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement or award of compensation. ORS 656.273(1). To prove a compensable worsening of his unscheduled low back 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). Finally, if the aggravation claim is submitted for an injury or disease for which permanent disability was awarded, claimant must establish that the worsening is more than a waxing and waning of symptoms contemplated by the last arrangement of compensation. ORS 656.273(8).

Here, the record includes medical opinions from the Orthopaedic Consultants, as an independent medical examiner, and Dr. Louie, claimant's treating neurosurgeon. The Consultants reported that a recent MRI had been interpreted as showing scarring around the L4 nerve root. The Consultants also mentioned some measurable left thigh atrophy. Noting claimant's comments that he felt "a lot worse," the Consultants concluded that claimant had subjectively, but not objectively worsened.

Dr. Louie's assessment was that claimant's condition had objectively worsened. Specifically, Dr. Louie referred to claimant's persistent decreased range of back motion, claimant's recurrent leg and back pain complaints. Dr. Louie did not consider claimant's recent episode to represent a temporary subjective worsening in a waxing and waning fashion. Rather, Dr. Louie explained that post-operative patients have occasional severe back strains as a result of residual mechanical back pain, which may require some time and palliative treatment.

Since Dr. Louie performed claimant's 1989 low back surgery and has treated claimant before and after this most recent episode, we find him to be in the best position to determine whether claimant's condition has worsened. See Jordan v. SAIF, 86 Or App 29 (1987); Kienow Food Stores v. Lyster, 79 Or App 416 (1986); Givens v. SAIF, 61 Or App 490 (1983). From his opinion and findings, as supported by the MRI "scarring" results and the Consultants' "atrophy" observations, we conclude that claimant has established a pathological worsening of his low back condition.

Alternatively, we conclude that claimant has established a worsening of symptoms which represents more than a waxing and waning of symptoms. In this regard, we note that prior to this recent episode, claimant had been released to light duty work, subject to a 20 pound maximum lifting limitation. Following this episode, Dr. Louie took claimant off work and prescribed a back brace and medication. We recognize that a worsened condition is not presumed to have been established by a physician's decision to release the claimant from work. ORS 656.273(1)(a). Nevertheless, in light of Dr. Louie's overall opinion and observations (particularly his express rejection of the suggestion that claimant's condition represented a waxing and waning of symptoms), we are persuaded that claimant's complaints were more than a waxing and waning of symptoms contemplated by his prior award.

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 attorney 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 case (as represented by claimant's appellant's brief and the record), the complexity of the issue, the value of the interest involved, and the risk that claimant's attorney's efforts would go uncompensated in this case.

ORDER

The Referee's order dated February 3, 1992 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. Claimant's attorney is awarded \$3,000 for services at hearing and on Board review, to be paid by SAIF.

In the Matter of the Compensation of
BRENDA K. ALLEN, Claimant
WCB Case No. 91-08314
ORDER ON REVIEW
Galton, et al., Claimant Attorneys
Stoel, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Podnar's order that upheld the insurer's denial of claimant's claim for a mental disorder and related physical symptoms. On review, the issue is compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's conclusions of law and opinion on the issue of compensability insofar as he found the physical component of claimant's claim noncompensable. Specifically, we agree that claimant has not met the burden of proving that her work activities were the major contributing cause of an increase in her preexisting headaches, gastrointestinal difficulty and backache conditions.

Claimant's claim also includes a mental component in the nature of depression with anxiety overlay. The Referee found that many of claimant's working conditions were not conditions generally inherent in every working situation, and that they existed in a real and objective sense. He also found that claimant has been diagnosed as having a mental disorder which is generally recognized in the medical or psychological community. We agree.

The Referee also found that claimant experienced work conditions of reasonable disciplinary, corrective or job evaluation actions by the employer. We agree. However, the Referee further concluded that actions by claimant's supervisor had "more effect upon claimant than she is willing or able to admit." We neither agree nor disagree with this statement. Rather, the medical evidence upon which we rely discusses claimant's interrelationships at work, yet concludes that her overtime and out-of-town travel work conditions are the major cause of claimant's mental disorder.

Finally, the Referee found that claimant failed to establish that her work activities were the major contributing cause of her mental disorder. Accordingly, the Referee concluded that claimant's depression with anxiety overlay condition is not compensable. We disagree.

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 opinion of Dr. Altfas.

Dr. Altfas, a psychiatrist, began treating claimant soon after her May 14, 1991 work incident. Claimant became emotionally distraught and was unable to complete her job duties. Dr. Altfas continued to treat claimant over a period of time. Dr. Altfas also consulted with Dr. Dlifton, claimant's family physician, and Dr. Mertens, a neurologist, throughout the course of claimant's treatment. Dr. Altfas diagnosed major depression which he attributed in major part to claimant's work conditions of overtime and out-of-town travel.

The Referee concluded that the opinion of Dr. Altfas was not persuasive because the physician allegedly did not discuss claimant's prior physical conditions or the possible effect of claimant's long-term medication use on her emotional status. We disagree, and find that Dr. Altfas did consider the effect of claimant's use of medications on her mental condition. His medical reports repeatedly make note of claimant's medicine intake. See Ex. 37; 39; 45; 55A. Moreover, Dr. Altfas discussed her overuse of medication with Mr. Mertens. (Ex. 55A-3). Thereafter, Dr. Altfas made adjustments to and monitored claimant's intake of prescription and non-prescription medications. (Ex. 55A-4). Afterwards,

Dr. Altfas continued to opine that claimant's work conditions were the major contributing cause of her psychiatric condition. We find Dr. Altfas' opinion persuasive. See Denise A. Lanter, 42 Van Natta 203 (1990) (doctor's opinion was found persuasive where the doctor subsequently became aware of other factors in regard to claimant's stress claim and his opinion was unchanged after becoming aware of the additional factors).

The Referee found Dr. Parvaresh's opinion to be persuasive. We disagree.

Dr. Parvaresh examined claimant once and did not review Dr. Altfas' reports. Dr. Parvaresh attributed claimant's psychiatric condition to her overuse of medication, but he failed to discuss Drs. Altfas' and Dr. Mertens' findings attributing claimant's rebound headache condition to this overuse, but not her mental disorder. Dr. Parvaresh acknowledged that claimant experienced a "grief process" after receiving modified work. Yet, Dr. Parvaresh subsequently indicated that after this modification, claimant ought to have been relieved of her depression. Finally, in analyzing what are or are not stressful working conditions, Dr. Parvaresh subjectively used his own working conditions and those of another patient as a barometer of claimant's work stress level.

Under the circumstances, we find Dr. Parvaresh's opinion to be neither well-reasoned nor persuasive. See Somers v. SAIF, 77 Or App 259 (1986). Rather, we rely upon Dr. Altfas' persuasive analysis. Accordingly, we conclude that claimant's work conditions were the major contributing cause of her mental disorder.

For prevailing on the issue of compensability of her mental disorder, 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 \$2,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and appellant's brief on review), the complexity of the issue and the value of the interest concerned.

ORDER

The Referee's order dated November 1, 1991 is affirmed in part and reversed in part. That portion of the Referee's order which upheld the insurer's denial insofar as it denied claimant's mental disorder is reversed. That portion of the denial is set aside and the mental disorder claim remanded to the insurer for processing according to law. The remainder of the order is affirmed. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of \$2,500, payable by the insurer.

November 10, 1992

Cite as 44 Van Natta 2268 (1992)

In the Matter of the Compensation of
ROBERT F. CURTIS, Claimant
Own Motion No. 91-0724M
OWN MOTION ORDER
Philip H. Garrow, Claimant Attorney
Williams, et al., Defense Attorneys

The self-insured employer has submitted claimant's request for temporary disability compensation for his compensable low back injury. Claimant's aggravation rights expired on April 28, 1991. The Board postponed action on the request for own motion relief on April 15, 1992 pending the outcome of WCB Case No. 91-13566.

By an Opinion and Order dated December 11, 1991, the Medical Director's review that found the proposed surgery to be reasonable was affirmed and the employer reopened the claim for temporary total disability compensation. The employer requests authorization for reimbursement from the Reopened Claims Reserve.

Claimant contends that he is not under the Board's own motion jurisdiction on the basis that he sustained a worsening prior to the expiration of his aggravation rights. We disagree.

In September 1990, claimant filed a claim for aggravation which was denied by the insurer. Thereafter, Dr. Kendrick recommended surgery. Claimant requested a hearing on this matter and a prior Referee concluded that claimant had not sustained a compensable aggravation. Claimant appealed the Referee's order to the Board. On May 15, 1992, we affirmed the Referee. Robert F. Curtis, 44 Van Natta 956 (1992), reconsidered 44 Van Natta 1118 (1992). In affirming the Referee, we found that although claimant had timely filed an aggravation claim, he had not established a compensable worsening. We further concluded that Dr. Kendrick's recommendation for surgery was part of the same aggravation claim. Following the expiration of his aggravation rights, claimant underwent the recommended surgical procedure.

Accordingly, although claimant did file a claim for a worsening prior to the expiration of his aggravation rights, he did not establish prior to expiration of those rights, that he in fact sustained a compensable worsening. Inasmuch as claimant did not sustain an aggravation, prior to the expiration of his aggravation rights, and because the alleged worsening (caused by the surgery and hospitalization) occurred after expiration of his aggravation rights, the present claim is solely within the Board's own motion jurisdiction. ORS 656.278(1)(a). Accordingly, we have jurisdiction over this matter.

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 find that claimant's low back condition did require surgery and the reopening of claimant's claim was appropriate. We, therefore, have the authority to confirm and authorize the reopening of claimant's claim for temporary disability compensation commencing September 25, 1991, the date of claimant's surgery. See ORS 656.278(1)(a). When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-12-055.

We are aware that litigation is pending regarding a Determination Order issued on September 11, 1990. (WCB Case No. 91-07555). One of the issues is whether claimant is permanently and totally disabled. At the conclusion of that hearing, the Referee shall forward a copy of his or her appealable order to the Board.

If it is found that claimant is permanently and totally disabled, we shall withdraw this own motion order and the employer shall be allowed credit for benefits paid pursuant to our own motion authority.

Finally, the employer also requests the Board to authorize reimbursement from the Reopened Claims Reserve pursuant to ORS 656.625. The Court of Appeals has held that the Board lacks the authority to grant or deny reimbursement from the Reserve. See SAIF v. Holmstrom, 113 Or App 242 (1992). Accordingly, we are unable to grant the employer's request.

IT IS SO ORDERED.

In the Matter of the Compensation of
LAVONA F. HARDING-GOLDEN, Claimant
WCB Case No. 91-13037
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review, and the insurer cross-requests review, of that portion of Referee Neal's order that awarded claimant 25 percent (37.5 degrees) scheduled permanent disability for loss of use or function of her right forearm and 30 percent (45 degrees) scheduled permanent disability for loss of use or function of her left forearm, whereas an Order on Reconsideration and Determination Order had awarded claimant no scheduled permanent disability. The insurer also cross-requests review of that portion of the order directing it 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 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 Scheduled Permanent Disability

The Referee found that claimant was not entitled to a rating for thumb prosthetic joint replacements pursuant to former OAR 436-35-110(7) because there was no evidence that the range of motion in claimant's hand and thumb had decreased or that the joint had ankylosed. However, the Referee did find that claimant had a loss of grip strength in both hands, therefore entitling her to awards of scheduled permanent disability.

Claimant asserts that she is entitled to an award under former OAR 436-35-110(7). Specifically, claimant contends that the Referee misinterpreted the rule by requiring that claimant prove an ankylosis of the joint and that the rule pertaining to ankylosis is only meant to be used to rate prosthetic joint replacements.

Claimant has had trapezium implant arthroplasty of the right and left thumbs. Former OAR 436-35-110(7) provides that "[p]rosthetic joint replacement of the joints of the fingers or thumbs are rated at one half the lowest ankylosis value for that joint." We agree with claimant's interpretation of the rule and find that the reference to ankylosis is for determining a rating and is not a requirement of proof of ankylosis of the joint. Therefore, claimant is entitled to a rating under former OAR 436-35-110(7). Under former OAR 436-35-050(4), the lowest ankylosis value for the thumb joint is 43 percent; claimant, therefore, is entitled to 21.5 percent for each thumb under former OAR 436-35-110(7).

The insurer asserts that claimant had preexisting loss of grip strength and that the loss of grip strength due to her most recent injury entitles her to 14 percent award for the left forearm and 15 percent award for the right forearm. The insurer bases its contention on a 1986 medical report which it asserts "inadvertently was not admitted into evidence when the parties streamlined the exhibit list."

We will consider documents on review that were not admitted at hearing if there is evidence that the Referee and parties intended to admit the document and the document was implicitly admitted. See e.g. Nellie M. Ledbetter, 43 Van Natta 570, 571 (1991). Such evidence includes inclusion of the document in the record certified by the Referee under ORS 656.295(3) and reference in the record by the Referee or parties. See e.g. Pete Topolic, 44 Van Natta 1604 (1992).

Here, the parties specifically agreed that certain documents would be admitted; although the 1986 medical report was submitted before hearing for inclusion in the record, it was not included in the documents which were admitted. (Tr. 1-5). The document therefore is not included in the record certified by the Referee and there is no reference to it in the record by the Referee or the parties.

Consequently, we conclude that there is a lack of evidence demonstrating that the document was intended to be admitted at hearing and we do not consider it on review. Having no evidence that claimant had loss of grip strength before her injury, the insurer's argument fails.

In the event that the insurer is moving for remand to admit the medical report, the motion is denied. We do not consider the record to be insufficiently, incompletely, or improperly developed. ORS 656.295(5). Moreover, we find no compelling reason to grant such a motion. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

Having determined that claimant is entitled to a rating of 21.5 percent for each thumb, we convert that rating to a hand value of 8.5 percent, see former OAR 436-35-070(4), and then to a forearm value of 6.5 percent, see former OAR 436-35-090(1). We then combine those values with the loss of grip strength values of 25 percent for the right forearm and 30 percent for the left forearm. See former OAR 436-35-120(4). Under that calculation, claimant is entitled to 29.875 percent for her right forearm and 34.55 percent for her left forearm. We then round these values to the next higher 1 percent step, resulting in a 30 percent award for the right forearm and 35 percent award for the left forearm. See former OAR 436-35-010(6).

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. Subsequent to the Referee's order, in SAIF v. Herron, 114 Or App 64 (1992), the Court of Appeals held that the amendment to ORS 656.214(2), which increased the rate of compensation for scheduled disabilities to \$305 per degree, was intended to apply to injuries that occurred on or after May 7, 1990.

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 Fees on Review

We note that the respondent's brief in reply to the insurer's cross-request for review was rejected as untimely and, therefore, it was not considered on review. Consequently, no attorney fee under ORS 656.382(2) shall be awarded for prevailing against the insurer's cross-request for review regarding the extent of disability. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated December 27, 1991 is modified in part and reversed in part. In lieu of the Referee's awards of scheduled permanent disability, claimant is granted awards of 30 percent (45 degrees) for her right forearm and 35 percent (52.5 degrees) for her left forearm. Those portions of the order directing the insurer to pay claimant's scheduled permanent disability award at the rate of \$305 per degree and awarding an out-of-compensation attorney fee payable from this compensation are reversed. The remainder of the order is affirmed. 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 for claimant's scheduled permanent disability award shall not exceed \$3,800.

In the Matter of the Compensation of
MARY J. JOSEPH-DUBY, Claimant
WCB Case Nos. 91-07194 & 90-18134
ORDER ON REVIEW
Brownstein, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys
Steve Cotton (Saif), Defense Attorney

Reviewed by Board Members Hooton and Brazeau.

Farmers Insurance Company requests review of Referee Spangler's order that: (1) set aside its denial of claimant's occupational disease claim for thoracic outlet syndrome; 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 reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the "FINDINGS OF FACT" section of the Referee's order, with the following modification.

In lieu of the Referee's finding that claimant quit working for Dr. Dewan in April 1991, we find that claimant quit working for Dr. Dewan sometime in mid-March 1991.

CONCLUSIONS OF LAW AND OPINION

The Referee applied the last injurious exposure rule and, finding that claimant's activities with Farmers' insured independently contributed to a worsening of her thoracic outlet syndrome (TOS), concluded that Farmers is responsible for the condition. On review, Farmers contends that the last injurious exposure rule does not apply because claimant's condition is attributable to her concurrent employment with both its insured and SAIF's insured. We agree.

In Colwell v. Trotman, 47 Or App 855 (1980), the Court of Appeals stated that the last injurious exposure rule was judicially created to place full responsibility for an occupational disease on the last of successive employers in whose service a worker was exposed to conditions contributing to the disease. The court explained that the adoption of the rule was necessary to relieve workers of the potentially impossible burden of proving the date of actual contraction of an occupational disease. Id. at 858 (citing Mathis v. SAIF, 10 Or App 139 (1972)). The court specifically expressed concern that a worker, who had been employed in the same trade with successive employers and developed a disease due to exposure in that trade, might file a claim against the wrong employer and later be barred by the filing limitations statute from filing a claim against the correct employer. Id.

The Colwell court stated, however, that the aforementioned rationale does not support application of the last injurious exposure rule to concurrent employment exposures, i.e., where the worker was exposed to conditions which contributed to an occupational disease in two separate but simultaneous employments. Id. The court noted, in particular, that a worker is unlikely to encounter filing limitation problems of the kind likely to arise in successive employment situations. Id. Therefore, the court declined to apply the rule to a concurrent employment situation.

In this case, claimant's employments were neither purely successive nor purely concurrent. Claimant was employed as a dental hygienist with Dr. Osterlind (SAIF's insured) and Dr. Dewan (Farmers' insured). She began working exclusively for Dr. Osterlind in January 1988. In June 1988, she began working concurrently for both Dr. Osterlind and Dr. Dewan. She generally worked one day a week for each employer. In January 1991, claimant began working two days a week for Dr. Dewan, while continuing to work one day a week for Dr. Osterlind. Claimant quit working for Dr. Osterlind on March 19, 1991. (See Tr. 45).

The evidence concerning the date that claimant quit working for Dr. Dewan is less clear. The Referee apparently relied on claimant's testimony that she quit working for Dr. Dewan in early April 1991. (See Tr. 23, 31). However, claimant's testimony is inconsistent with the documentary evidence.

Dr. Dewan's payroll records show that claimant was last paid for work performed through the week ending March 15, 1991. (Ex. 11-7). Moreover, in a letter dated April 9, 1991, Dr. Radecki reported claimant's history that "she has now stopped working for the past three weeks." (Ex. 7-1). Thus, Dr. Radecki's letter is consistent with Dr. Dewan's payroll records that claimant left Dewan's employ sometime in mid-March 1991.

Because the aforementioned documents were prepared closer in time to the date in question, we find them to be more reliable than claimant's testimony on this issue. Accordingly, we find that claimant quit working for Dr. Dewan sometime in mid-March 1991, approximately the same time she left Dr. Osterlind's employment.

Inasmuch as claimant worked six months for Dr. Osterlind before working for Dr. Dewan, this case does not present a purely concurrent employment situation. Nonetheless, we find that the policy rationale cited by the Colwell court for not applying the last injurious exposure rule to concurrent employment situations applies with equal force to this case. As the Colwell court explained:

"[I]n a concurrent employment situation, at least when, as here, the simultaneous employments end at essentially the same time, the worker is extremely unlikely to encounter limitation problems of the kind which would be likely to arise in successive employment situations." Id. at 860.

Inasmuch as claimant's simultaneous employments ended at approximately the same time, we find that Colwell is analogous to the facts of this case. Therefore, we do not apply the last injurious exposure rule to these facts.

Turning to the merits, we find that claimant's work activities as a dental hygienist were the major contributing cause of her thoracic outlet syndrome (TOS). Dr. Anderson, claimant's attending physician, opined that the dental hygienist work was the major contributing cause of the TOS, though he could not apportion responsibility for the TOS between the two employers. (Ex. 4). Dr. Radecki, the examining physician, attributed claimant's complaints to an idiopathic fibrositis syndrome and/or possible psychological etiologies. (Ex. 7). For the reasons discussed by the Referee, we find Dr. Anderson's opinion to be more persuasive. (See O&O p. 5).

On review, SAIF argues that in response to a letter from Farmers, Dr. Anderson opined that claimant's employment with Dr. Dewan was the major cause of the TOS. We disagree. The letter advised Dr. Anderson that claimant had worked six months for Dr. Osterlind before commencing work with Dr. Dewan, and it asked if the longer period of employment with Dr. Osterlind was the major contributing cause of the TOS. Dr. Anderson responded: "Not necessarily, but the employer she had last." (Ex. 8).

Dr. Anderson's response is conclusory and vague. He does not give any reasoning to explain the statement. Moreover, it is not clear what history he relied on in making the statement. He may have relied on history that claimant continued to work for Dr. Dewan for several weeks after leaving Dr. Osterlind's employment. As we discussed above, however, that history is unreliable in the face of documentary evidence that claimant quit both jobs at approximately the same time. Therefore, we do not find Dr. Anderson's conclusory opinion to be persuasive evidence that either employment was the major cause of the TOS. Rather, we find that claimant's work activities for both employers were the major contributing cause of the TOS.

We next address each employer's relative responsibility for the TOS. Claimant was under contract with both employers and under each employer's separate control. She performed services separately for each employer. The services she performed for each employer, though virtually identical in nature, were unrelated to the services she performed for the other. Therefore, we find that this case presents a "dual employment" situation. See Mission Insurance Co. v. Miller, 73 Or App 159, 163 (1985) (citing 1C Larson, Workmen's Compensation Law, § 48.40 (1982)); David R. Abbott, 44 Van Natta 132 (1992); Dallas H. Greenslitt, 40 Van Natta 1038 (1988).

In a dual employment case, the employers may be held responsible for compensation separately or jointly, depending on the severability of the employee's activities at the time of "injury." Mission

Insurance Co. v. Miller, supra. This case concerns an occupational disease, rather than an injury. The date or time of contraction of the disease cannot be established with the same degree of certainty that the time of an injury can be established. We have found, however, that the TOS resulted from virtually identical activities performed for both employers. Under these circumstances, there is no rational basis for assigning responsibility separately to either employer. Rather, we conclude that the employers must be held jointly responsible for claimant's TOS and any resulting disability and need for treatment.

Accordingly, we hold both Farmers and SAIF jointly responsible for the processing of claimant's claim. For the apportionment of compensation due as a result of claimant's condition, the insurers are referred to the procedures set forth in OAR 436-60-195.

Farmers has requested review and claimant's compensation has not been reduced or disallowed. Consequently, claimant's attorney would ordinarily be entitled to an attorney fee for services on review. ORS 656.382(2). However, inasmuch as claimant's attorney did not file a brief on Board review, no attorney fee shall be assessed. Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated August 19, 1991, as reconsidered October 9, 1991, is reversed in part and affirmed in part. That portion of the order that upheld the SAIF Corporation's denial is reversed. SAIF's denial is set aside. SAIF and Farmers Insurance Company are jointly responsible for processing claimant's claim, including petitioning of the Director for apportionment. The Referee's attorney fee award shall be paid by SAIF and Farmers in equal shares. The remainder of the order is affirmed.

November 10, 1992

Cite as 44 Van Natta 2274 (1992)

In the Matter of the Compensation of
RAEJEAN M. NEWELL, Claimant
 WCB Case No. 91-10389
 ORDER ON REVIEW
 Welch, et al., Claimant Attorneys
 Cummins, et al., Defense Attorneys

Reviewed by Board Members Hooton and Brazeau.

The self-insured employer requests review of Referee Leahy's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. 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 employer contends that claimant's carpal tunnel syndrome is not causally related to her employment and that the Referee's reliance on Dr. Schreoter's opinion was misplaced, because Dr. Schreoter was not the treating physician.

A licensed medical doctor who is primarily responsible for the treatment of a worker's compensable injury is an attending physician. ORS 656.005(12)(b)(A). A doctor who examines a worker or the worker's medical record to advise the attending physician regarding treatment of a worker's compensable injury is a consulting physician. ORS 656.005(12)(c). On January 3, 1991, claimant saw Dr. Schreoter, M.D., for complaints of numbness in both arms. Dr. Schreoter referred claimant to Dr. Mertens, neurologist, for nerve conduction studies and evaluation. Accordingly, we find that Dr. Schreoter is claimant's attending physician and Dr. Mertens is a consulting physician. ORS 656.005(12)(b)(A) and 656.005(12)(c). Claimant has been diagnosed with bilateral carpal tunnel syndrome, for which she has been treated by Drs. Schreoter and Mertens. This diagnosis has been established by medical evidence supported by objective findings. (Exs. 3, 6-8, 6-9).

Compensability

We adopt the Referee's opinion on this issue with the exception of paragraphs 5, 6 and 8 on page 3, and with the following supplementation. Not only did Dr. Nathan have an incorrect history of claimant's work activities (see ex. 10-2), which were different and more intense since her move to Portland, but he states that it is "more likely" that claimant's condition is age-related and attributes her condition to "physiological changes in [claimant's] cardiovascular system," a cause that is unsupported by any persuasive evidence.

On the other hand, Dr. Schreoter persuasively opined that claimant's symptoms, i.e., her carpal tunnel syndrome, are work related because of the repetitive nature of her job.

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 \$1,000, 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 December 2, 1991 is affirmed. Claimant's attorney is awarded \$1,000 for services on Board review, to be paid by the self-insured employer.

November 10, 1992

Cite as 44 Van Natta 2275 (1992)

In the Matter of the Compensation of
ROBERT E. PETERSON, Claimant
 WCB Case Nos. 91-14724 & 91-11830
 ORDER ON REVIEW
 Phillip S. Swogger, Claimant Attorney
 John Snarskis, Defense Attorney
 Lester Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Hooton and Brazeau.

The SAIF Corporation requests review of those portions of Referee Nichols' order that: (1) set aside its denial of claimant's "new injury" claim for a low back condition; and (2) upheld Industrial Indemnity's denial of claimant's aggravation claim for the same condition. Additionally, Industrial Indemnity moves to strike SAIF's appellant's brief for SAIF's failure to serve Industrial Indemnity with a copy of its brief. On review, the issues are motion to strike brief, compensability and responsibility.

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

Motion to Strike

OAR 438-11-020(2) provides that the party requesting Board review shall file its appellant's brief to the Board within 21 days after the date of mailing of the transcript of record to the parties. Additionally, OAR 438-05-046(2)(a) provides that a true copy of anything filed under the Board's rules shall be simultaneously served to each other party, or to their attorneys.

Here, SAIF concedes that it failed to serve a copy of its appellant's brief on Industrial Indemnity or its attorney. However, we find that any prejudice which may have resulted from SAIF's omission was subsequently cured. By letter dated March 20, 1992, the Board's Chief Staff Attorney revised the parties' briefing schedule to permit claimant and Industrial Indemnity an additional 30 days in which to file their respective respondents' briefs. Under these circumstances, we deny Industrial Indemnity's motion to strike. See David F. Weich, 39 Van Natta 468 (1987).

Compensability/Responsibility

The Referee concluded that responsibility for claimant's low back condition shifted to SAIF, based on the finding that claimant sustained a new compensable injury while employed by SAIF's insured, and that the injury materially contributed to his subsequent disability and need for treatment. Citing ORS 656.005(7)(a)(B), SAIF argues that because claimant sustained a prior compensable injury to his low back with Industrial Indemnity's insured, the record must establish that the June 26, 1991 work incident with SAIF's insured was the major contributing cause of claimant's subsequent disability and need for treatment. We disagree.

Subsequent to the Referee's order, we held in Rosalie S. Drews, 44 Van Natta 36 (1992), that ORS 656.005(7)(a)(B) is not applicable to the issue of whether responsibility for a condition shifts to a subsequent insurer under ORS 656.308(1). Accordingly, notwithstanding claimant's prior compensable back injury with Industrial Indemnity's insured, a new compensable back injury with SAIF's insured is established under ORS 656.308(1) where the later injury is a "material contributing cause" of claimant's subsequent disability or need for treatment.

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 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 issues, and the value of the interest involved.

ORDER

The Referee's order dated December 12, 1991 is affirmed. Claimant's attorney is awarded \$1,200 for services on Board review, to be paid by the SAIF Corporation.

 November 12, 1992

Cite as 44 Van Natta 2276 (1992)

In the Matter of the Compensation of
ROBERT D. BLANCHFIELD, JR., Claimant
 WCB Case No. 91-01777
SECOND ORDER ON RECONSIDERATION (REMANDING)
 W. D. Bates, Jr., Claimant Attorney
 Employers Defense Counsel, Defense Attorney

On October 22, 1992, we issued an Order on Reconsideration remanding this matter to the Referee for further proceedings. On our own motion, we withdraw our prior order and issue the following order.

Claimant contends that this matter should be remanded to the Referee for further consideration. In support of this contention claimant has attached a letter from James Bridges, a witness at the hearing, purporting to withdraw his testimony at hearing. In the letter, Mr. Bridges indicates that he is withdrawing his testimony because, due to illness, he was confused and did not properly remember facts to which he testified.

We first note that our review is limited to the record developed at hearing. ORS 656.295(5). Therefore, we are not authorized to consider the evidence submitted by claimant on review. However, we may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." Id.

Here, the Referee found the testimony of Mr. Goff and Mr. Bridges credible and stated:

"In contrast, the persuasiveness of claimant's testimony is diminished by his poor recollection, which may have been [sic] contributed to the deficiencies in the history of Dr. Hacker, who was unaware of claimant's slip on the ice or his hunting and football activities."

Under these circumstances, we conclude that claimant's credibility and reliability relative to that of Mr. Goff and Mr. Bridges were central considerations in the Referee's conclusion. In view of Mr. Bridges' letter, we conclude that the record before the Referee was incompletely developed. See Jose L. Cervantes, 41 Van Natta 2419 (1989). In reaching this conclusion, we wish to emphasize that we are not stating that a witness can "withdraw" testimony that has already been given. Rather, we conclude that, in this case, the post-hearing purported retraction of testimony from a pivotal witness is of such significance that it deserves consideration by the Referee who rendered the initial decision. Our conclusion is limited to the facts presented in this case.

Accordingly, we withdraw our August 7, 1992 Order on Review. On reconsideration, we vacate the Referee's order dated September 6, 1991. This matter is remanded to the Referee for further proceedings to determine whether and to what extent the letter from Mr. Bridges affects the ultimate outcome of this dispute. These further proceedings may be conducted in any manner that the Referee determines will achieve substantial justice. Following these further proceedings, the Referee shall issue a final appealable order concerning the issues raised in this case.

IT IS SO ORDERED.

November 12, 1992

Cite as 44 Van Natta 2277 (1992)

In the Matter of the Compensation of
PAMELA S. CHENEY, Claimant
WCB Case No. 91-10153
ORDER ON RECONSIDERATION
Deich & Meece, Claimant Attorneys
Jerome P. Larkin (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our October 14, 1992 Order on Review in which we concluded that SAIF had formally accepted claimant's herniated disc at L4-5 and awarded claimant's attorney an assessed fee under ORS 656.386(1) for obtaining compensation for claimant without a hearing by obtaining SAIF's acceptance. SAIF contends that neither issue was raised at hearing and therefore were not properly before us. We disagree.

Although the issue of the scope of SAIF's acceptance was not raised in claimant's several requests for hearing, it was sufficiently raised at hearing. See tr. at 11, 18, 19 and 20. Therefore, we appropriately considered it. Furthermore, even though an attorney fee in this matter was not specifically requested, we find that once we resolved the compensability issue, the attorney fee issue naturally flowed from our statutory authority to award it. See ORS 656.386(1). We consequently adhere to our prior order.

Accordingly, we withdraw our October 14, 1992 order. On reconsideration, as supplemented herein, we adhere to our October 14, 1992 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID T. HANER, Claimant
WCB Case No. 91-03404
ORDER ON RECONSIDERATION
Popick & Merkel, Claimant Attorneys
Beers, et al., Defense Attorneys
D. Kevin Carlson, Assitant Attorney General

The insurer requested reconsideration of our October 15, 1992 Order on Review, which vacated the Referee's order and remanded for further proceedings. On October 30, 1992, we abated our order to allow claimant an opportunity to respond. Inasmuch as claimant's response has been received, we proceed with our reconsideration.

The insurer has raised numerous matters for clarification. First, the insurer notes that, although we vacated the Referee's order for further proceedings concerning whether claimant's need for additional medical treatment is causally related to his compensable injury, we also agreed with the Referee's conclusion that the Hearings Division lacked jurisdiction to review the Director's order disapproving palliative care. As a result, the insurer questions whether the new hearing will again address the jurisdictional issue. The answer is no. This case is remanded solely for purposes of determining the causal relationship issue. However, in making the determination, the Referee shall have the discretion to proceed in any manner that will achieve substantial justice to all parties. ORS 656.283(7).

The insurer also notes that our order indicates that the matter is remanded to Referee Knapp, despite the fact that Referee Knapp has retired. We acknowledge the error. The October 15, 1992 Order on Review is corrected to provide that this matter is remanded to the Presiding Referee for assignment to an available Referee.

The insurer next contends that there is a question as to what would be litigated at the remand proceedings, because there was no de facto denial of medical services. We disagree. As we stated in our original order, in addition to challenging the Director's order regarding palliative care, claimant raised as an issue in his request for hearing the "causal relationship of medical treatment/condition." While the insurer did not issue a written denial on causation grounds in response to claimant's request for continued medical treatment, we find that the issue of a de facto denial of services was raised by the insurer's failure to respond to claimant's inquiry as to whether it intended to deny the services in reliance on the Director's determination of noncompensability. As a result, claimant is entitled to a hearing on the question of whether his need for additional medical treatment is causally related to his compensable injury.

The insurer also indicates that there is no justiciable controversy because the medical services in question have already been denied by the Director. However, as is evident from the director's January 14, 1991 order, that decision was based on his determination that the medical treatment was not related to the compensable injury. The Director does not have the authority to base his decision on the causal relationship of the treatment to the compensable injury. Therefore, the outcome of this hearing should cause reevaluation of the underlying dispute of whether claimant is entitled to the requested medical treatment.

Accordingly, our October 15, 1992 order is withdrawn. On reconsideration, as supplemented and corrected herein, we adhere to and republish our October 15, 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
WENDY J. NELSON-COX, Claimant
WCB Case No. 90-08608
ORDER ON REVIEW
Minturn, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Emerson's order that upheld the insurer's denial of claimant's aggravation claim for a current left carpal tunnel syndrome (CTS) condition. On review, the issues are compensability, penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

FINDING OF ULTIMATE FACT

Claimant's "off work" activities were the major contributing cause of her current disability and/or need for treatment for her left CTS condition.

CONCLUSIONS OF LAW AND OPINION

In order to establish a compensable aggravation, claimant must prove that her 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).

We have held that, although a compensable worsening is generally established by the "material contributing cause" test, if an off-the job injury or work exposure is the major contributing cause of the worsened condition, the worsening is not compensable under ORS 656.273(1). See Lucky L. Gay, 44 Van Natta 2172 (1992); Elizabeth A. Bonar-Hanson, 43 Van Natta 2578 (1991), aff'd mem Bonar-Hanson v. Aetna Casualty Company, 114 Or App 233 (1992).

Here, the Referee found that claimant failed to prove a compensable worsening of her accepted left carpal tunnel syndrome (CTS) condition, because she did not establish that her work activities for the employer were a material contributing cause of her current left CTS condition. However, the parties do not seriously dispute that claimant's left CTS began with her work for the employer or that the insurer accepted claimant's claim for that condition. Nor does the insurer contend that the current claim is for a condition other than the one which it accepted. Rather, the insurer argues that claimant's work activities subsequent to her covered employment with the employer are the major contributing cause of her disability and/or need for treatment for her current left CTS condition. (See Ex. 36).

Under these circumstances and on this record, we find that claimant's current condition is the same as the accepted condition and that claimant's work for the employer is a material contributing cause of her left CTS which has worsened since the last arrangement of compensation, thus diminishing claimant's earning capacity. We further find that claimant's worsened left CTS condition is established by medical evidence supported by objective findings.

Because the insurer denied the aggravation claim on the grounds that off-the-job activities are the major contributing cause of claimant's worsened condition, we next consider whether the insurer has carried its burden of proving that contention. See Roger D. Hart, 44 Van Natta 2189 (1992).

The record contains conflicting medical evidence concerning the causal contribution from claimant's activities after she stopped working for the employer on April 9, 1987. In determining which medical opinion is persuasive, we generally give greater weight to the conclusions of a treating

physician. However, we do not so defer when there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). In this case, we find such reasons.

Dr. Arbeene, treating orthopedist, opined, without explanation, that claimant's work as "nanny and housekeeper, subsequent to 1987, was not the major contributing cause to her developing left carpal tunnel syndrome, nor of her need for surgery for that condition[.]" (Ex. 37). However, Arbeene previously opined that claimant "is not capable of working as a housecleaner and I have asked her to avoid that type of work. She is also incapable of typing and I suggested that she avoid all kinds of work which require repetitive use of her left hand and wrist." (Ex. 31). We find Arbeene's conclusory opinion concerning causation incongruous with his earlier recommendation that claimant avoid the very work which he later said is not the cause of claimant's left CTS. Under these circumstances, we do not find Arbeene's unexplained conclusion to be well-reasoned and we decline to rely on it.

On the other hand, we find the opinion of Dr. Nye, hand surgeon, to be well-reasoned and based on an accurate history. (See Exs. 33, 34, 35). Nye opined that claimant's current need for left CTS surgery is due to the pathological worsening of the left CTS condition which occurred after claimant left her job for the employer in 1987. (Ex. 34). Specifically, Nye stated that claimant's housecleaning work was the major contributing cause of her current need for treatment. (Ex. 35). Based on Nye's opinion, we conclude that the insurer has carried its burden of proving that "off work" factors are the major contributing cause of claimant's current problems. See Lucky L. Gay, supra.¹ Thus, claimant's aggravation claim for a worsened left CTS condition fails. Compare Roger D. Hart, supra.

Finally, we note claimant's argument that, under ORS 656.308, the insurer remains responsible for the accepted condition unless claimant sustained a new injury during later employment. However, ORS 656.308 is not applicable here, because only one covered employer is potentially responsible. See Lucky L. Gay, supra, (ORS 656.308(2) does not apply where the "other employer" is claimant himself, and claimant has no workers' compensation insurance"). In reaching this conclusion, we note, as we did in Lucky L. Gay, that an allegation that noncovered employment activities are the cause of a worsened condition is not treated as a responsibility issue. Id.

Because claimant's aggravation claim is not compensable, there is no basis for a penalty or attorney fee award related to that claim. Accordingly, claimant's request for penalties and fees is denied.

ORDER

The Referee's order dated January 28, 1992 is affirmed.

¹ Member Gunn would direct the parties to his dissent in Lucky Gay, supra.

November 12, 1992

Cite as 44 Van Natta 2280 (1992)

In the Matter of the Compensation of
ROSA J. RAMIREZ, Claimant
 WCB Case No. 91-12966
 ORDER ON REVIEW
 Michael B. Dye, Claimant Attorney
 John B. Motley (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of that portion of Referee McCullough's order that directed it to pay claimant's award of scheduled permanent partial disability at \$305 per degree. Claimant cross-requests review of those portions of the order that: (1) declined to award temporary total disability compensation for the period of June 30, 1990 through December 19, 1990; and (2) declined to assess penalties and attorney fees for SAIF's allegedly unreasonable failure to pay temporary total disability for that period. On review, the issues are rate of scheduled permanent disability, entitlement to temporary disability, 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

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).

Although SAIF timely requested review, it filed no appellant's brief and its reply brief was untimely; therefore, we do not consider it.

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 March 16, 1989 compensable injury. ORS 656.202(2); former ORS 656.214(2).

Temporary Total Disability

The parties stipulated at hearing that claimant was medically stationary on October 6, 1990, the medically stationary date affirmed by the Order on Reconsideration. Her claim was closed by Determination Order on December 19, 1990 which awarded temporary total disability from January 30, 1990 through February 18, 1990. An Order on Reconsideration affirmed this award.

Claimant argues that Dr. James, M.D., was her attending physician at the time he filled out a Form 827 on June 30, 1990. Therefore, she argues, based on Dr. James' Form 827, she is entitled to temporary total disability compensation from June 30, 1990 through October 6, 1990 on a substantive basis, and through December 19, 1990 on a procedural basis. Relying primarily on his conclusion that Dr. James was not claimant's attending physician, the Referee found that claimant was not entitled to temporary total disability beyond that affirmed by the Order on Reconsideration. We agree that claimant has not established entitlement to temporary total disability for the period from June 30, 1990 through December 19, 1990. However, we base our conclusion on the following reasoning.

As a preliminary matter, because claimant was medically stationary on October 6, 1990, the question of her procedural entitlement to temporary total disability compensation beyond that date is moot. An injured worker is substantively entitled to temporary disability compensation from the onset of disability until the condition is medically stationary. In Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992), the court held that "[p]ayment of temporary disability benefits beyond the medically stationary date is a consequence of the administrative process of claim closure and is not an entitlement." Thus, the Board has no authority to impose an overpayment beyond the medically stationary date where a processing delay did not result in an overpayment. Id. Instead, the appropriate method to induce compliance is to award penalties, if an insurer unreasonably delays or refuses to pay temporary disability benefits. Id.

We proceed to discuss claimant's substantive entitlement to temporary total disability compensation from June 30, 1990 through October 6, 1990. Although a claimant's procedural entitlement for all periods of time during an open claim is contingent upon authorization by the

attending physician of temporary disability, see OAR 436-30-036(1), there is no such requirement for determining a claimant's substantive entitlement to temporary disability benefits. Rather, a claimant's substantive entitlement to temporary total disability is determined on claim closure and is proven by a preponderance of the evidence in the entire record showing that the claimant was disabled due to the compensable claim before being declared medically stationary. ORS 656.210; Lebanon Plywood v. Seiber, supra; Esther C. Albertson, 44 Van Natta 2058 (1992).

Here, Dr. Stevens, attending physician, released claimant for regular work as of February 19, 1990. (Ex. 5A). On June 30, 1990, claimant was examined by Dr. James who checked the box on a Form 827 indicating that claimant was not released for work. (Ex. 7-1). However, whatever persuasiveness this "check" had is undermined by Dr. James' notations on the Form 827 and in his chart note. On the Form 827, Dr. James noted "? disability," indicating that he questioned claimant's disability status. (Ex. 7-1). Furthermore, in his chart note, Dr. James characterized claimant's disability as "possible." (Ex. 7A). Given the equivocal nature of Dr. James' opinion, we do not find it to be persuasive evidence that claimant was unable to work from June 30, 1990 through October 6, 1990 due to the compensable injury.

There is no other medical opinion regarding claimant's ability to work during that period. Although claimant was examined by Dr. Hazel, orthopedist, on July 5, 1990, he did not authorize any time loss. (Exs. 7B, 7C, 8A).

On this record, we do not find that claimant has proved by a preponderance of the evidence that she was disabled due to the compensable injury for the period from June 30, 1990 through October 6, 1990.

Penalties and Attorney Fees

The Referee found that SAIF was not unreasonable in failing to pay temporary total disability compensation for the period in question. We agree.

SAIF received Dr. James' Form 827 on July 5, 1990. (Ex. 7-3). As of that date, claimant was not yet medically stationary. Therefore, the question is whether SAIF was unreasonable in failing to begin payment of procedural temporary disability compensation upon receipt of the Form 827. We find that it was not.

As noted above, procedural entitlement to temporary disability compensation is contingent upon authorization by the attending physician of temporary disability. OAR 436-30-036(1). Claimant was released to her regular work by her attending physician, Dr. Stevens, as of February 19, 1990. There is no evidence that claimant changed her attending physician subsequent to that release and SAIF's receipt of the June 30, 1990 Form 827. Furthermore, assuming arguendo that Dr. James became claimant's attending physician, given the equivocal nature of his opinion, SAIF was not unreasonable in failing to begin paying temporary disability compensation on the basis of that opinion.

ORDER

The Referee's order dated March 17, 1992 is reversed in part and affirmed in part. Those portions of the order which directed the SAIF Corporation to pay claimant's scheduled permanent disability award at \$305 per degree and awarded an attorney fee payable from this increased compensation are reversed. Claimant's scheduled permanent disability award is to be paid at the rate in effect at the time of her compensable injury. The remainder of the order is affirmed.

In the Matter of the Compensation of
JANICE S. BROWN, Claimant
WCB Case No. 91-07341
ORDER OF ABATEMENT
Malagon, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Claimant has requested reconsideration of our Order on Review dated October 15, 1992.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and the SAIF Corporation is requested to file a response to the motion within ten days.

IT IS SO ORDERED.

November 13, 1992

Cite as 44 Van Natta 2283 (1992)

In the Matter of the Compensation of
JUANITA DICKSON, Claimant
WCB Case No. 91-05871
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Terrall & Associates, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The self-insured employer requests review of those portions of Referee Hoguet's order that: (1) set aside its partial denial of claimant's claim for her neck condition; (2) found that its denial of a work-hardening program had no effect as it denied the program on the grounds that it was not reasonable or necessary; and (3) found that a Notice of Closure and Order on Reconsideration had prematurely closed claimant's claim. On review, the issues are compensability, medical services and premature claim closure. 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 established that her compensable 1989 injury was the major cause of her current chronic myofascial syndrome of the left neck. We affirm with the following supplementation.

On review, the employer contends that a prior Referee found that claimant had failed to establish a worsening of her compensable condition. The employer notes that, in arriving at his conclusion, the prior Referee considered the report of Dr. Thomas, one of claimant's former examining physicians. The employer contends that, because of the prior Referee's finding, the Referee in this case may not rely on the same opinion of Dr. Thomas to find that claimant has established compensability of her neck condition. We disagree.

We first note that the Referee's conclusion regarding compensability was based upon the opinions of both Dr. Thomas and Dr. Winans, claimant's current treating physician. Furthermore, the Referee found, and we agree, that the record contains no contrary medical opinion on the causation issue. Finally, the prior Referee's finding was limited to a conclusion that claimant's compensable condition had not worsened since March 20, 1991. Therefore, we do not agree with the employer's contention that Dr. Thomas' April 1990 diagnosis of myofascial syndrome of the left neck, directly related to the compensable 1989 injury, was necessarily dispositive to the prior Referee's finding of no worsening since March 1991.

Accordingly, we adopt the Referee on the issue of compensability.

Medical services

The Referee concluded that the employer's denial was null and void as the employer could only pay claimant's bills or initiate Director review of the dispute. See Stanley Meyers, 43 Van Natta 2643 (1991). On review, the employer argues that the work-hardening program prescribed by Dr. Winans was palliative treatment that was not properly authorized.

We find that the issue of whether claimant's treatment was palliative or curative was not raised at hearing. Moreover, we have previously concluded that, even if such an issue is raised, neither the Board nor the Hearings Division has jurisdiction over matters regarding whether certain kinds of treatment constitute palliative care. See Gladys M. Theodore, 44 Van Natta 905 (1992). Accordingly, we decline to address the employer's argument regarding palliative care.

Premature closure

The Referee concluded that, because he had found claimant's myofascial syndrome compensable, the May 21, 1991 Notice of Closure and the August 29, 1991 Order on Reconsideration were premature.

On review, the employer contends that the opinion of Dr. Winans, claimant's treating physician, is not persuasive. The employer also argues that claimant has merely established fluctuating symptoms or a continuing need for medical treatment, which does not necessarily indicate that her condition can be expected to materially improve.

On February 22, 1991, the Western Medical Consultants examined claimant and found that her lumbosacral sprain and left buttock contusion had resolved. The Consultants also noted that claimant exhibited signs of a chronic pain syndrome with "no evidence of functional overlay for secondary gain or continued compensation." The Consultants concluded that claimant was medically stationary as of the date of the examination, and the employer closed claimant's claim with a May 21, 1991 Notice of Closure.

On March 26, 1991, Dr. Winans reported that he had been treating claimant since earlier that month for spasm and reactive trigger points. Although Dr. Winans found that claimant's contusion was insignificant, he opined that claimant continued to have somatic dysfunction and acute fibromyositis. He anticipated reducing the frequency of claimant's treatments if she continued to "progress with improvement." Finally, Dr. Winans reported that claimant was not medically stationary. He referred claimant to "Back In Action." On May 10, 1991, Dr. Slack, Medical Director for "Back In Action," reported that claimant's condition "should respond positively" to comprehension therapy.

Under the circumstances, we agree with the Referee that claimant's claim was prematurely closed by the May 21, 1991 Notice of Closure. We further agree with the Referee's reliance on the opinion of Dr. Winans, who had the opportunity to examine claimant on more than one occasion and who provided continuing treatment for her condition. We conclude that his opinion establishes that claimant's condition could be expected to materially improve and we agree that claimant was not medically stationary at the time of claim closure. We therefore affirm the Referee on the issue of premature claim closure.

Claimant is entitled to an assessed attorney fee for successfully defending against the employer's request for review. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services on Board review is \$1,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the complexity of the issues, the time devoted to the case (as represented by claimant's respondent's brief) and the value of the interest involved.

ORDER

The Referee's order dated March 10, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of \$1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
CARL R. ALATALO, Claimant
WCB Case No. 91-12629
ORDER ON RECONSIDERATION
Malagon, et al., Claimant Attorneys
Cummins, et al., Defense Attorneys

Claimant requests reconsideration of our October 14, 1992 order which: (1) found that an Order on Reconsideration was invalid because the reconsideration order issued without the appointment of a medical arbiter; (2) set aside the Order on Reconsideration; and (3) declined to "remand" the case to the Department. Enclosing a copy of a Department letter refusing to "reopen the reconsideration process," claimant asks that we expressly remand this case to the Department for issuance of a proper reconsideration order.

As discussed in our prior order, we are without authority to "remand" this case to the Department. See Mickey L. Platz, 44 Van Natta 1056 (1992). Our reasoning for such a conclusion is that because of the invalidity of the Order on Reconsideration, jurisdiction over this dispute has never left the Department. As demonstrated by claimant's recent submission, we are aware that the Department does not agree with the Board's holding in Olga I. Soto, 44 Van Natta 697 on recon 44 Van Natta 1609 (1992), which supports a conclusion that the present reconsideration order is invalid and that authority to proceed with the reconsideration process remains with the Department.

We empathize with the parties' predicament in this Soto case. Nevertheless, if claimant objects to the Department's apparent refusal to take further action, that is for claimant to take up with the Department. In any event, the Department's disagreement with the Soto holding and its current position regarding the current dispute does not alter our prior reasoning and conclusions.

For the reasons expressed in Soto and Platz, our authority in cases such as this is confined to determining the validity of the reconsideration order. Inasmuch as we completed that determination and concluded that the reconsideration order was invalid, we are without authority to remand this case because jurisdiction to complete the reconsideration process still remains with the Department. Consequently, we deny claimant's request that we remand this case to the Department for issuance of a proper Order on Reconsideration.

Accordingly, our October 14, 1992 order is withdrawn. On reconsideration, as supplemented herein, we republish our October 14, 1992 order. The parties' 30-day statutory rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

November 16, 1992

Cite as 44 Van Natta 2285 (1992)

In the Matter of the Compensation of
ELER M. COUSIN, Claimant
WCB Case Nos. 90-02206, 90-01738, 91-08532, 90-01737 & 90-02205
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Williams, et al., Defense Attorneys
Terrall & Associates, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Knapp's order that: (1) upheld Lumbermen's Underwriting Alliance's "back-up" denial of claimant's aggravation claim for a bilateral hand condition; and (2) upheld Liberty Northwest Insurance Corporation's "back-up" denial of claimant's occupational disease claim for the same condition. On review, claimant contends that the denials were invalid or, alternatively, that she has established the compensability of her current condition. We affirm.

FINDINGS OF FACT

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

Claimant returned to work in October 1988 rather than August 1988.

At the April 5, 1991 hearing regarding responsibility, the Referee held the record open for 30 days in order to allow the insurers to issue denials of compensability. (Tr. 68). On April 30, 1991, Lumbermen's issued such a denial. (Ex. 49). On June 17, 1991, claimant filed a request for hearing regarding the denial. That matter was consolidated with the issue of responsibility.

At hearing on October 2, 1991, Liberty orally issued a denial of compensability and claimant orally requested a hearing regarding the denial. (Tr. 78). That matter was consolidated with the remaining matters in order to litigate it at the hearing. (Tr. 77-78).

CONCLUSIONS OF LAW AND OPINION

Applicable law

The Referee concluded that responsibility should be determined under the law prior to the 1990 amendments but, because claimant requested hearings regarding the denials of compensability after May 1, 1990 and the hearing regarding that issue was convened after July 1, 1990, the issue of compensability should be determined under the 1990 amendments. See Or Laws 1990 (Special Session), ch 2, § 54(2). Claimant contends that this conclusion is incorrect, asserting that the compensability denials "relate back" to the denials of responsibility issued by the insurers in December 1989 and January 1990, and therefore, that the compensability issue should be considered as having been "convened" during the initial May 31, 1990 hearing. We disagree with claimant's contentions.

The issuance of an order pursuant to ORS 656.307 specifically and officially notifies a claimant that compensability of her claim has been accepted. See David D. Allen, 43 Van Natta 2458, 2460 (1991). In this case, therefore, compensability was no longer in dispute as of the time of the issuance of the "307" order on January 25, 1990. Accordingly, claimant's first request for hearing necessarily concerned only the issue of responsibility, thereby preventing the subsequent denials of compensability from "relating back" to the date of the first request for hearing. Claimant's June 17, 1991 and October 2, 1991 requests for hearing therefore are the relevant dates for determining the compensability issue.

Furthermore, because compensability of the claim was accepted as a matter of law at the time of the initial hearing, a hearing on that specific issue was not "convened" on that date. Although the initial hearing was continued, the continuances related only to the issue of responsibility. The issue of compensability merely was consolidated with the issue of responsibility for administrative economy and convenience of the parties. Thus, a hearing on the issue of compensability was not "convened" until the October 2, 1991 hearing, when that matter was litigated.

Claimant next contends that the 1990 amendments to ORS 656.262(6) apply only to claims accepted on or after the enactment date of May 7, 1990. Claimant bases this argument on the use of the present tense in the statute, when it provides that, "if the insurer or self-insured employer accepts a claim in good faith but later obtains evidence that the claim is not compensable," the carrier "may revoke the claim acceptance and issue a formal denial" at any time up to two years after claim acceptance. (Emphasis added.)

We disagree with claimant's interpretation of ORS 656.262(6). The statute's use of the present tense does not demonstrate an intent to limit ORS 656.262(6) to only those claims accepted on or after May 7, 1990. Section 54(1) provides that "this 1990 Act becomes operative July 1, 1990, and * * * applies to all claims existing or arising on and after July 1, 1990, regardless of date of injury, except as specifically provided in this section." (Emphasis added). This language evidences an intent that only Section 54 is to determine the applicability of the new Act, independent of the other provisions. Consequently, we consider the tense of the term "accepts" in ORS 656.262(6) to be irrelevant when determining the applicability of the new amendments. Furthermore, we note that Section 54(3) limits applicability of some amendments to "all claims which become medically stationary after July 1, 1990"

and that, if the legislature had intended to also limit the applicability of ORS 656.262(6), it could have included the statute in this section rather than signalling such an intent using the term "accepts."

Thus, we agree with the Referee that the current version of ORS 656.262(6) was applicable in determining the validity of the "back-up" compensability denials. See Carlson v. Valley Mechanical, 115 Or App 371 (1992).

Compensability

Under ORS 656.262(6), the insurers must prove by clear and convincing evidence that the claim is not compensable. We agree with the Referee that the insurers carried this burden and adopt that portion of his opinion.

ORDER

The Referee's order dated October 15, 1991 is affirmed.

November 16, 1992

Cite as 44 Van Natta 2287 (1992)

In the Matter of the Compensation of
JULIA E. HAMILTON, Claimant
WCB Case No. 91-16621
ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Michael Johnson's order that affirmed an Order on Reconsideration that increased claimant's scheduled permanent disability award for loss of use or function of the left leg from 10 percent (15 degrees), as awarded by Determination Order, to 16 percent (24 degrees). On review, the issue is extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following correction. Claimant compensably injured her left kneecap, displacing the patella. (Ex. 4).

CONCLUSIONS OF LAW AND OPINION

Claimant contends that her right knee has a normal flexion of 150 degrees, not the 140 degrees found by the Referee, and that, therefore, her comparative loss of range of motion should be 14 percent, not 12 percent. We disagree for the same reasons put forth by the Referee and affirm and adopt his opinion on this issue.

Claimant also contends that she has an additional ratable loss due to laxity of the medial patellar ligament under OAR 436-35-230(3). The ratable loss allowed for knee joint instability under OAR 436-35-230(3) must be due to instability of the medial collateral, not patellar, ligament. However, the Department and the Referee awarded 5 percent for a chronic condition which limits repetitive use. A review of the medical arbiter's report indicates that the laxity of the patellar ligament was the basis for the finding that claimant experienced a chronic condition limiting repetitive use. The medical evidence does not demonstrate that claimant has experienced a loss of use or function for that condition which exceeds the 5 percent allowed. Accordingly, we affirm and adopt the Referee's opinion on this issue as well.

ORDER

The Referee's order dated March 6, 1992 is affirmed.

In the Matter of the Compensation of
JULIO G. MEJIA, Claimant
WCB Case No. TP-92010
THIRD PARTY DISTRIBUTION ORDER ON RECONSIDERATION
Doblie & Associates, Claimant Attorneys
Roberts, et al., Defense Attorneys

Claimant requests reconsideration of our October 22, 1992 Third Party Distribution Order which: (1) found that Travelers Insurance Company, as a paying agency, was entitled to recover \$18,819.80 as its actual claim costs from a third party judgment; and (2) deferred ruling on whether Travelers was entitled to a lien for anticipated future expenditures, as well as any permanent disability resulting from the motor vehicle accident which had resulted in the third party judgment, until issues of premature closure and extent of permanent disability are ultimately determined.

On reconsideration, claimant has submitted an October 26, 1992 letter from Dr. Conrad, M.D., which provides an opinion regarding the extent of permanent disability attributable to the auto accident. The letter also discusses whether, as a result of the motor vehicle accident, claimant will require future medical care for his knees.

We decline to reopen the record for submission of Dr. Conrad's report. Dr. Conrad's report is dated after the issuance of our Third Party Distribution Order, and claimant has provided no evidence that the document could not have been produced, with due diligence, prior to the issuance of our distribution order. Finally, we note that before our order issued, claimant apparently agreed that the record was adequately developed, as on September 14, 1992, claimant requested that the "record be closed and a decision made based upon the record as it now stands." See Donald P. Bond, 40 Van Natta 361, on recon 40 Van Natta 480 (1988).

Under the circumstances, we find that the present record is sufficient to sustain judicial review under ORS 656.298. Blackman v. SAIF, 60 Or App 466, 448 (1982). Claimant's request to reopen the record for submission of Dr. Conrad's report is, therefore, denied.

Finally, we conclude that even if Dr. Conrad's report were to be admitted, its contents would have no effect upon our decision. We point out that, due to pending hearing requests on the issues of premature closure and extent of permanent disability, our order specifically deferred ruling on whether Travelers was entitled to a lien for permanent disability benefits, as well as future medical expenses. Therefore, prior to the final resolution of those issues, we find that any report regarding claimant's extent of permanent disability is unnecessary to the disposition of this matter.

Accordingly, the request for reconsideration is granted and our October 22, 1992 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our October 22, 1992 Third Party Distribution Order in its entirety, effective this date. 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
BERTHA PANIAGUA, Claimant
WCB Case No. 92-00275
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Lundeen, et al., Defense Attorney

Reviewed by Board Members Moller and Neidig.

The insurer requests review of Referee Daughtry's order that found that a Determination Order had prematurely closed claimant's injury claim. On review, the issue is premature closure, and alternatively, extent of scheduled and unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Premature closure

The Referee concluded that, because the insurer had failed to strictly comply with an administrative rule allowing claim closure, the Determination Order had prematurely closed claimant's claim. On review, the insurer contends that its notice was proper and that claim closure was permitted by the administrative rules.

Before addressing the insurer's argument regarding the sufficiency of its notice, we first determine whether claimant has met her burden of proof to establish that she was not medically stationary at the time her claim was closed.

Under ORS 656.268(1), claims shall not be closed if the worker's condition has not become medically stationary. "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). It is claimant's burden to show that she was not medically stationary on the date of closure. Berliner v. Weyerhaeuser, 54 Or App 624 (1981).

Claimant sustained a compensable injury in July 1990. She treated with Dr. Mitchell, M.D., who diagnosed chronic bursitis of the back and shoulder. In August 1990, Dr. Mitchell reported that it would be several months before claimant became medically stationary. In September 1990, Dr. Mitchell reported that medications would not substantially change claimant's overall condition, and she would not be able to work for long periods of time at her prior occupation.

On October 11, 1990, Dr. Mitchell checked a box indicating that claimant was not medically stationary. He stated that he anticipated claimant becoming medically stationary in November 1990.

On November 29, 1990, Dr. Mitchell reported that claimant's thoracic strain was resolving but she was not medically stationary. He further reported that, "[f]or the time being there will be no therapy or medications."

On December 28, 1990, Dr. Mitchell reported that claimant had told him in November that she might be pregnant, and if that was true, she would not be medically stationary. He advised her to stop medications and stated that claimant would be re-evaluated in one month.

In February 1991, Dr. Mitchell reported that claimant had not returned to his office since her November 29, 1990 visit. He also noted that claimant had miscarried on December 25, 1990.

Claimant's claim was subsequently closed by a June 11, 1991 Determination Order which found her medically stationary as of April 18, 1991.

We conclude that claimant has failed to establish that, as of June 11, 1991, further material improvement in her condition could reasonably be expected from medical treatment or the passage of time. Claimant was last seen by Dr. Mitchell in November 1990. Dr. Mitchell's December 1990 opinion that claimant was not medically stationary relied upon the fact that claimant was pregnant. However, claimant's pregnancy ended in December 1990. In addition, claimant testified that the medications prescribed by Dr. Mitchell did not improve her condition. (Tr. 5). Finally, claimant also testified that the reason she did not return to treat with Dr. Mitchell is that his treatment did not help her. (Tr. 5).

Under the circumstances, we find that claimant has failed to establish that she was not medically stationary at the time of the June 11, 1991 Determination Order. We therefore reverse the Referee on the issue of premature closure. The Determination Order is reinstated.

Finally, because we have concluded that claimant has failed to establish that her claim was prematurely closed, the issue of notice pursuant to OAR 436-30-035(7) is moot.

Extent of permanent disability

At hearing, the issue of extent of scheduled and unscheduled permanent disability was raised in the alternative. Because we have found that claimant's claim was not prematurely closed and the record is sufficiently developed, we proceed to rate extent of permanent disability.

On this record, we are unable to find that claimant has permanent impairment that is ratable under the standards. Dr. Mitchell's chartnote of October 10, 1990 reports that claimant had full range of motion. Claimant has pointed to no evidence in the medical record to support an award of permanent disability. We therefore affirm the Determination Order and Order on Reconsideration.

ORDER

The Referee's order dated April 6, 1992 is reversed. The June 11, 1991 Determination Order and the Order on Reconsideration are reinstated and affirmed. The Referee's approved attorney fee is also reversed.

November 16, 1992

Cite as 44 Van Natta 2290 (1992)

In the Matter of the Compensation of
JOANNE C. ROCKWELL, Claimant
WCB Case Nos. 90-15323 & 90-12621
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

Claimant requests review of that portion of Referee Knapp's order which found that her occupational disease claim for her right carpal tunnel syndrome was untimely filed, and was therefore, not compensable. In its brief, EBI Companies disagrees with the Referee's alternative finding that, if claimant's right carpal tunnel condition was timely filed, it is compensable and EBI is responsible. EBI contends that CNA Insurance Company is responsible. In its brief, CNA contends that, if the Referee's alternative finding is reached, EBI should be found responsible. On review, the issues are timeliness of filing, and alternatively, compensability and responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant filed her request for hearing after May 1, 1990 and the hearing convened on November 5, 1990. Consequently, we analyze this matter under the Workers' Compensation Law as amended effective July 1, 1990. See Ida M. Walker, 43 Van Natta 1402 (1991).

Timeliness

On review, claimant argues that, in finding that her occupational disease claim was untimely, the Referee incorrectly applied ORS 656.807(1)(a)(b). Claimant contends that her occupational disease claim was timely filed as she had a year to file her claim after the time she became disabled and left work in May 1989.

Because claimant's right and left carpal tunnel syndrome conditions arose at different times and the parties and the Referee have treated the conditions independently for purposes of compensability and responsibility, we separately address the timeliness of each claim.

Right carpal tunnel syndrome

Claimant first started treating with Dr. Brookhart, M.D., in January 1988 for her right wrist pain. At that time, Dr. Brookhart diagnosed right carpal tunnel condition and reported that the condition was work-related.

The Referee concluded that claimant had one year from January 1988 to file her occupational disease claim as January 1988 was the date upon which claimant was informed by a physician that she was suffering from an occupational disease. We agree.

ORS 656.807(1) provides that:

"All occupational disease claims shall be void unless a claim is filed with the insurer or self-insured employer by whichever is the later of the following dates:

"(a) One year from the date the worker first discovered, or in the exercise of reasonable care should have discovered, the occupational disease; or

"(b) One year from the date the claimant becomes disabled or is informed by a physician that the claimant is suffering from an occupational disease.

In Bohemia Inc. v. McKillop, 112 Or App 261 (1992), the court held that the phrase "the later of the following dates" modifies each clause within subparagraphs (a) and (b) and, therefore, the relevant date was the later of the dates in each subparagraph. The court further held that the legislature intended that the dates in subparagraph (a) are alternative dates to be compared with the dates in subparagraph (b) to determine the later date. In McKillop, therefore, the court found that the claimant had timely filed her occupational disease claim, as the claim was filed within one year of the time she became disabled.

Claimant contends that the Referee erred by finding that her claim had to be filed within one year from January 1988, which was the first time she was informed by her physician that she had an occupational disease. Rather, claimant argues that, pursuant to 656.807(1), she had one year to file her occupational disease claim from the time she became disabled in May 1989.

Although the Referee's analysis of the "later date" to be used for filing may not have been accurate under the McKillop case, we conclude that he reached the correct result. We reach that conclusion because we do not find that claimant became disabled and left work in May 1989 due to her right carpal tunnel condition.

The Referee found, and we agree, that claimant did not miss time from work because of her symptoms. Following the initial diagnosis of right carpal tunnel syndrome, claimant continued to work in the same position until she left work in May 1989 for reasons unrelated to her condition. Claimant

testified at hearing that she was able to continue work and that she was not disabled and did not leave work due to her wrist condition. (Tr. 17-18).

Under the circumstances, we conclude that the Referee properly found that the correct date for determining commencement of the filing period was January 1988, the date upon which claimant first was informed by a doctor of her occupational disease. As noted by the court in McKillop, *supra*, that is also the date upon which claimant first discovered the occupational disease. Therefore, claimant had until January 1989 to file her occupational disease claim for her right carpal tunnel condition. Because she did not file her claim until February 1990, we agree with the Referee that her right carpal tunnel condition is untimely.

Claimant alternatively argues that, even if her occupational disease claim was untimely filed, the insurers have failed to show prejudice due to the delay in filing.

Neither EBI nor CNA argues that it has been prejudiced by claimant's failure to timely file her occupational disease claim. Rather, both insurers argue that ORS 656.807(1), the statute which sets forth filing limitations for occupational disease claims, does not place the same proof of prejudice imposition upon employers as ORS 656.265, the statute providing for filing of occupational injuries. Finally, although CNA concedes that prior court and Board case law required that an insurer or employer prove that it was prejudiced due to an untimely filing of an occupational disease claim, CNA argues that the "new" statute (ORS 656.807 was amended in 1987) should be more narrowly interpreted by the Board.

We find no reason to construe current ORS 656.807(1) more narrowly than its predecessor statute. We find no changes in the language of the current statute and the insurers have provided no legislative history supporting an intent to omit the requirement of a showing of prejudice that has been previously read into the statute by the court and the Board. Accordingly, we continue to follow the rationale expressed in Robinson v. SAIF, 69 Or App 534 *rev den* 238 (1984), in which the court held that ORS 656.807(1) cannot be viewed in isolation and the procedure for processing occupational disease claims is the same as provided for accidental injuries, including a requirement that to prevail on a timeliness defense, an insurer must prove prejudice due to the late filing. *Also see* Inkley v. Forest Fiber Products Co., 288 Or 337 (1980); Charlene Newman, 43 Van Natta 368 (1991).

In the present case, neither insurer has provided any argument or contention that it has been prejudiced by claimant's untimely filing of her occupational disease claim for her right carpal tunnel condition and we are unable to find evidence in the record of such prejudice. Accordingly, we proceed to address the merits of claimant's claim.

In an alternative finding, the Referee concluded that, if claimant's occupational disease claim had been timely filed, it was compensable. We agree with the Referee's alternative conclusion that claimant has established compensability of her right carpal tunnel condition, and we adopt his "Conclusions of Law and Opinion" on that issue. Consequently, we reverse the Referee's initial finding that claimant's right carpal tunnel claim is not compensable.

Left carpal tunnel condition

Claimant was first diagnosed with bilateral carpal tunnel condition in March 1990. Therefore, to the extent that claimant has made a claim for her left carpal tunnel condition, we find that her occupational disease claim has been timely filed.

However, although claimant's claim for her left carpal tunnel condition was timely, we agree with the Referee's conclusion that the condition is not compensable. We adopt his "Conclusions of Law and Opinion" on that issue.

Responsibility

For purposes of review, the Referee found EBI responsible for claimant's right carpal tunnel syndrome condition. We agree, however, we apply the following analysis.

Here, although claimant's claim is analyzed under the "new" law, we conclude that Section 49 of SB 1197, codified at ORS 656.308 does not apply, as claimant does not have an accepted right carpal tunnel condition. See Fred A. Nutter, 44 Van Natta 854 (1992) (application of ORS 656.308(1) assumes that there is a compensable condition and the initially responsible insurer is seeking to shift further liability to another insurer.) We, therefore, apply the last injurious exposure rule for assignment of responsibility purposes.

In occupational disease cases, 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 she first seeks medical treatment for the condition. Progress Quarries v. Vaandering, 80 Or App 160 (1986); SAIF v. Carey, 63 Or App 68 (1983); Inez Horsey, 42 Van Natta 331 (1990). Once liability initially is fixed, responsibility may not be shifted forward to a subsequent employer unless that employer's work conditions contributed to the cause of, aggravated or exacerbated the underlying disease. Bracke v. Baza'r, *supra*; Fred Meyer v. Benjamin Franklin Savings & Loan, 73 Or App 795, *rev den* 300 Or 162 (1985).

Here, before October 1, 1988, the employer was insured by CNA. After that date, it became insured by EBI. Claimant, who worked as a computer operator, first sought treatment for right hand and wrist problems in January 1988 while CNA was on the risk. Claimant did not file a claim because she thought her symptoms would resolve. Subsequently, claimant left work in May 1989 for reasons unrelated to her condition.

Accordingly, we conclude that, because claimant has not lost any time from work due to her right wrist condition, the onset of disability is the date upon which claimant first sought treatment. Because claimant first sought treatment in January 1988, while CNA was on the risk, we conclude that CNA is responsible for claimant's right wrist condition and responsibility cannot be shifted unless a more recent employment worsened claimant's underlying condition. Actual, not potential, causation is required to shift responsibility. See Riley E. Lott, 43 Van Natta 209 (1991).

In the present case, CNA insured the employer from the time claimant first started working in 1983 until EBI came on the risk on October 1, 1988. Therefore, to shift responsibility to EBI, CNA must establish that claimant's work after October 1, 1988 actually contributed to her condition.

Dr. Brookhart treated claimant in January 1988 for her right wrist condition and subsequently treated her for similar symptoms in February 1990. Dr. Brookhart also referred claimant to Dr. Mason, neurosurgeon, for examination and nerve conduction studies. In March 1990, Dr. Brookhart reported that claimant's condition was secondary to her six years of work as a computer operator. In addition, Dr. Mason agreed that, if claimant continued to work as a computer operator in 1988 and 1989, the continued employment would have contributed to a worsening of her carpal tunnel condition. Dr. Mason testified in deposition that every day claimant worked as a data entry person caused a continued, independent contribution to her carpal tunnel condition. (Ex. 19-55).

Under the circumstances, we find that the medical evidence establishes that claimant's work as a computer operator after October 1, 1988, when EBI came on the risk, contributed to a worsening of her underlying condition. Therefore, we conclude that responsibility has shifted from CNA to EBI.

For prevailing on the issue of compensability of her right carpal tunnel condition, 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 \$2,200, to be paid by EBI, the insurer held responsible for claimant's condition. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs on review), the complexity of the issue and the value of the interest concerned. We note that claimant is not entitled to a fee for services rendered with regard to her unsuccessful appeal of compensability of her left carpal tunnel condition.

ORDER

The Referee's order dated May 6, 1991 is reversed in part and affirmed in part. EBI Companies' denial of claimant's right carpal tunnel condition is set aside and the claim is remanded to EBI for processing according to law. EBI's denial which denied compensability of claimant's left carpal tunnel condition is upheld. The remainder of the Referee's order is affirmed. For services at hearing and on Board review, claimant's counsel is awarded a reasonable attorney fee of \$2,200 payable by EBI.

November 16, 1992

Cite as 44 Van Natta 2294 (1992)

In the Matter of the Compensation of
EDWIN J. VANDEHEY, Claimant
WCB Case No. 91-13840
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Thomas J. Castle (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of Referee Lipton's order that awarded claimant 36 percent (115.20 degrees) unscheduled permanent disability for a low back injury, whereas an Order on Reconsideration had awarded no permanent disability. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the third to last and last paragraphs contained in the "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant was entitled to 36 percent unscheduled permanent disability based on the opinion of Dr. Spencer, internal medicine specialist. SAIF asserts that Dr. Spencer's opinion is not sufficient to entitle claimant to such an award.

On January 29, 1991, claimant was examined by Dr. Pasquesi, orthopedic surgeon, during an independent medical examination. Dr. Pasquesi noted claimant's complaints of worsened symptoms with repetitive bending, stooping or twisting. Dr. Pasquesi found that claimant did not have measurable impairment, but that he did have "discomfort" due, in part, to the compensable injury. (Ex. 15-4).

Prior to the examination by Dr. Pasquesi, on August 3, 1990, claimant was examined by Dr. Spencer. Dr. Spencer later testified during a deposition that claimant's retained lumbar flexion at that time "was probably 30, 40 degrees and the extension 20 degrees" and "right and left rotation was probably 20 degrees." (Ex. 23-7). However, during his deposition, Dr. Spencer further stated that "although you may have today testified that you found some limitations in his range of motion back in August of 1990, you do not necessarily believe that those same limitations existed in January, 1991 based on Dr. Pasquesi's report[.]" (Ex. 23-13).

We find that Dr. Spencer agreed with Dr. Pasquesi that claimant did not demonstrate measurable impairment as of January 1990 based on a reduced range of motion. Therefore, unlike the Referee, we find no basis for awarding impairment values based on limited range of motion. However, we further find that Dr. Spencer's agreement with Dr. Pasquesi's report was limited to the range of motion findings. During his deposition, Dr. Spencer also stated that claimant's condition would prevent him from repetitively bending, stooping, twisting, and lifting in excess of 20 pounds. (Ex. 23-8). Based on this opinion, as well as Dr. Pasquesi's notation of similar complaints from claimant, we are persuaded that claimant is entitled to a 5 percent rating for a chronic condition limiting the repetitive use of his low back. Former OAR 436-35-320(5)(b).

We agree with the Referee that the appropriate value for claimant's age is +1 and, for formal education, 0. However, we conclude that, because claimant testified that he operated a backhoe and a CAT, his highest SVP value is +2. See former OAR 436-35-300(4)(e); DOT 850.683-034. Moreover, we find that such abilities establish that claimant has training in a specific vocational pursuit beyond an entry-level position. Therefore, claimant is not entitled to a value for training. Former OAR 436-35-300(5)(b); Larry L. McDougal, 42 Van Natta 1544 (1990).

Finally, claimant returned to work at a modified job and then was subsequently laid off. Accordingly, we hold that his adaptability should be computed under former OAR 436-35-310(3). Lorene E. Yost, 43 Van Natta 2321 (1991). Based on the record, we find that claimant's job at the time of his compensable aggravation was medium (Tr. 9) and that he returned to work in the light category. Therefore, claimant's adaptability value equals +2. Former OAR 436-35-310(3).

The sum of claimant's age value and education value is 3. When that value is multiplied by the adaptability value, 2, the product is 6. When that value is added to claimant's impairment value, 5, the result is 11 percent unscheduled permanent partial disability.

ORDER

The Referee's order dated January 22, 1992 is modified. In lieu of the Referee's unscheduled permanent partial disability award and in addition to the Notice of Closure award of 7 percent (22.4 degrees), claimant is awarded 4 percent (12.8 degrees), giving claimant a total award to date of 11 percent (35.2 degrees) unscheduled permanent disability for a low back injury. The Referee's attorney fee award is modified accordingly.

November 17, 1992

Cite as 44 Van Natta 2295 (1992)

In the Matter of the Compensation of
ELTON R. HUMPHREY, Claimant
WCB Case No. 91-08256
ORDER ON REVIEW
Ackerman, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerland.

Claimant requests review of Referee Gruber's order that upheld the SAIF Corporation's partial denial of a surgery claim for a cervical condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following exceptions and supplementation. We do not adopt the first sentence of the findings of fact or the last two paragraphs of the ultimate findings of fact.

On July 20, 1978, claimant sought medical treatment for "chest pains." (Ex. A). During that examination, claimant related that he fell and hurt his cervical spine a week or two earlier. No abnormalities regarding the cervical spine were found, and no treatment was rendered regarding the cervical spine. (Ex. A).

On April 4, 1982, claimant rolled his log truck and suffered contusions on his left ribs, a lumbar spine strain, and a cervical spine sprain. (Ex. 1). His treatment regarding these injuries consisted of pain medication and rest. (Ex. 1). Claimant completely recovered from these injuries.

Claimant was diagnosed with cervical degenerative disc disease (DDD) in July 1985. (Ex. 3-2). He was essentially asymptomatic in regard to his preexisting cervical DDD prior to the June 25, 1990 compensable work injury. He reported minor neck pain when consulting his physician regarding various other medical complaints in December 1987, May 1988, and July 1989. (Exs. 5-1, 5-2). He last

reported "neck discomfort" in July 1989, almost a year before the compensable work injury. Prior to the compensable injury, excluding diagnostic x-rays, claimant received no medical treatment directed at his cervical spine. His occasional minor neck pain did not prevent him from performing his duties as a log truck driver.

Following the compensable injury, claimant experienced a significant increase in neck pain with "pins and needles" down his neck into his right shoulder. Claimant's increased symptomology continued despite conservative treatment directed at his cervical spine which involved cortisone injections and physical therapy. In October 1990, claimant quit his job because, due to pain, he was no longer able to perform his duties as a log truck driver which included putting tire chains on the truck in bad weather. (Tr. 21).

Claimant's June 1990 compensable cervical sprain injury caused his preexisting asymptomatic degenerative disc disease to become symptomatic. The major contributing cause of claimant's current disability and need for medical treatment for this resultant condition is and remains the compensable injury.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's compensable injury on June 25, 1990 was not the major contributing cause of his need for an anterior cervical discectomy and fusion at C4-5. We disagree.

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 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.*; Dale P. Ballou, 44 Van Natta 1087 (1992).

Because SAIF accepted claimant's June 25, 1990 cervical and thoracic sprain as a compensable injury, we need not address whether claimant has established a compensable injury under the first prong of this two-part test. However, as to the second prong of the test, we find that the cause of claimant's current disability and need for surgery is a complex medical question requiring expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985).

Here, the record contains the opinions of Dr. Kintz, attending physician, Dr. Macha, treating orthopedist, Dr. Gallo, treating neurosurgeon, Dr. Woolpert, examining orthopedist, and Dr. Stanford, SAIF's in-house medical advisor who performed a record review. It is undisputed (we note preliminarily) that claimant had preexisting cervical degenerative disc disease. The record does not support compensability of this preexisting condition, and claimant does not contest SAIF's September 23, 1991 partial denial of cervical spondylosis and right arm radiculitis.

Although Dr. Kintz opined that it was likely that the work injury exacerbated claimant's preexisting cervical DDD and caused his subsequent increase in symptoms, he deferred to Dr. Macha regarding claimant's need for surgery. (Ex. 32). Thus, Dr. Kintz provides no opinion regarding the cause of claimant's need for surgery.

Drs. Gallo, Macha, and Woolpert all relate claimant's current condition and need for surgery to the same cause -- the preexisting cervical DDD narrowed the foraminal area sufficiently so that the work incident caused irritation of the nerve root. (Exs. 23-4, 30-1, 33-1). The question presented is which element of that cause, the DDD or the injury, is the major contributing cause of claimant's current disability and need for surgery.

Dr. Gallo opined that the work injury is the major cause of the current material worsening. (Ex. 33-1). She relates claimant's increased symptoms, which she finds are caused by the work injury, to the

current need for surgery because she finds that claimant does not have enough cervical instability to require surgery without symptoms. (Ex. 33-2). SAIF argues that Dr. Gallo's opinion is not persuasive because she earlier stated that claimant had no problems at all with his neck until the injury. However, at the time that Dr. Gallo gave her opinion regarding the cause of the need for surgery, she had an accurate history of claimant's prior minor neck complaints. (Ex. 33-6).

Furthermore, although there are inconsistencies in Dr. Macha's opinion regarding causation, we interpret his opinion, as a whole, to mean that claimant's need for surgery at this time is caused in major part by the work injury. (Ex. 30). In other words, both Drs. Macha and Gallo found that, but for the work injury, claimant would not require the proposed cervical surgery at this time.

Dr. Woolpert relates the need for surgery to the DDD. (Ex. 23). However, he does not consider the fact that, prior to the work injury, claimant had never required any medical treatment for his occasional minor neck pain and had not reported any neck pain for nearly a year before the work injury. He also does not consider claimant's significant increase in symptoms following the work injury and his lack of benefit from conservative care. Because of these omissions, we do not find Dr. Woolpert's opinion persuasive.

Finally, Dr. Stanford opined that the major contributing cause of claimant's condition is the preexisting degenerative changes in his cervical spine. (Ex. 26). Dr. Stanford discounted Dr. Gallo's opinion that the work injury was the cause of claimant's current problem because he considered her to have an inaccurate history regarding claimant's past neck pain. However, as discussed above, we find that, at the time Dr. Gallo rendered her opinion regarding causation, she had an accurate history. Furthermore, Dr. Stanford finds that, if claimant never had any neck pain prior to his work injury, then the work injury would be a cause of his neck pain and need for surgery. (Ex. 26-1). However, like Dr. Woolpert, Dr. Stanford does not consider claimant's essentially asymptomatic condition prior to the work injury and his significant symptomatic increase following the work injury. Therefore, for the same reasons that we find Dr. Woolpert's opinion unpersuasive, we also find Dr. Stanford's opinion unpersuasive.

Relying on the well reasoned opinion of Dr. Gallo, as supported by the opinion of Dr. Macha, we find that claimant has established by a preponderance of the evidence that the compensable injury is the major contributing cause of his current disability and need for cervical surgery. Accordingly, SAIF's denial of claimant's current condition will be set aside.

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 \$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 and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated December 30, 1991 is reversed. The SAIF Corporation's June 21, 1991 denial is set aside, and the claim is remanded to SAIF for processing according to law. For services at hearing and on review concerning the compensability issue, claimant's counsel is awarded an assessed attorney fee of \$4,000, payable directly to claimant's counsel by SAIF.

In the Matter of the Compensation of
DARJA LOCKETT, Claimant
WCB Case Nos. 90-21926 & 91-11571
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of Referee Livesley's order that: (1) set aside its denial of claimant's "new injury" claim for her current bilateral upper extremity cumulative trauma disorder, carpal tunnel syndrome (CTS), and tenosynovitis conditions; and (2) upheld Liberty Northwest Insurance Corporation's (Liberty) denial of claimant's aggravation claim for the same conditions. Claimant cross-requests review, asserting that, if the Board finds her claim compensable against Liberty, penalties and attorney fees should be assessed against Liberty for an allegedly unreasonable denial. On review, the issues are compensability, responsibility, penalties, and attorney fees. We reverse.

FINDINGS OF FACT

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

The Western Medical Consultants' report referred to in paragraphs six and seven is dated March 31, 1990, not 1991.

The mild flexor tenosynovitis diagnosed by Dr. Becker on December 20, 1990 was located in claimant's right fourth finger. (Ex. 45).

CONCLUSIONS OF LAW AND OPINION

The Referee found claimant's claim compensable. He also found that responsibility shifted to SAIF as insurer for the subsequent employer based on his finding that the diagnosis of flexor tenosynovitis constituted a "new injury." We agree that claimant's claim is compensable, with the exception of her alleged carpal tunnel syndrome (CTS). However, we disagree that responsibility shifts to SAIF.

Compensability

New Injury or Occupational Disease

We first address whether claimant's current condition is the result of a new injury or new occupational disease occurring at SAIF's insured. Here, after her return to work following the closure of her claim with Liberty's insured, claimant's symptoms were not sudden in onset. Instead, claimant had a gradual increase in her bilateral upper extremity symptoms. Consequently, this claim is properly analyzed as an occupational disease. See ORS 656.802(1)(c); see also Valtinson v. SAIF, 56 Or App 184 (1982); Brenda M. Winship, 42 Van Natta 2443 (1990).

In November 1989, Liberty accepted as compensable claimant's occupational diseases of bilateral upper extremity overuse syndrome and right ring trigger finger. (Ex. 12). This is a case in which several diagnoses have been given for the same condition, both during and after claimant's work activities at Liberty's insured. The parties recognized this fact and agreed that, for the purposes of this claim, the terms "cumulative trauma disorder," "overuse syndrome," "myofascial pain," and "fibromyalgia" mean the same thing and describe the whole of claimant's pain complaints.

The medical record supports this agreement. Dr. Catlin, attending doctor of osteopathy, has treated claimant for her bilateral upper extremity condition since claimant's original complaints of upper extremity pain while working at Liberty's insured. Dr. Catlin summarized claimant's treatment history, including her various diagnoses, and explained that there was no difference in the diagnoses of myofascial pain syndrome and bilateral upper extremity overuse syndrome. (Ex. 51-2). She also noted

that the multiple consultants have reached very similar diagnoses of either upper extremity overuse syndrome, myofascial pain syndrome or fibromyalgia. Id. Furthermore, Dr. Becker, consulting rheumatologist, noted that claimant had a diffuse myofascial pain problem in the upper extremities, no matter what it was called. (Ex. 36).

SAIF argues that claimant did not sustain a new occupational disease during her employment at its insured. It argues that claimant continued to suffer from the same conditions previously accepted by Liberty. We agree.

To establish a new occupational disease, the work at SAIF's insured must be the major contributing cause of the condition or a pathological worsening of the underlying condition. ORS 656.802(1)(c); 656.802(2); Aetna Casualty Co. v. Aschbacher, 107 Or App 494 (1991). A symptomatic worsening is not sufficient to establish a compensable occupational disease. Aschbacher, supra. Here, there is no evidence of anything more than a symptomatic worsening of the conditions previously accepted by Liberty.

Only Drs. Catlin and Becker address the issue of whether claimant sustained a new condition. Dr. Catlin essentially found that claimant continues to suffer from a bilateral upper extremity overuse syndrome which has subjectively worsened during her employment at SAIF's insured. (Ex. 51).

Dr. Catlin notes that she "did not find clear cut objective evidence of worsening." (Ex. 51-2). We find that this statement refers to a worsening of the underlying condition. We base that finding on the fact that, in reliance on claimant's reports of increased pain, Dr. Catlin referred her to an orthopedist, Dr. Butters, and a rheumatologist, Dr. Becker, in hopes that they might be able to provide additional treatment to relieve the pain. Although that satisfies the requirement of objective medical findings to support compensability, it does not establish that the occupational disease has pathologically worsened. See Georgia-Pacific Corp. v. Ferrer, 114 Or App 471 (1992); Suzanne Robertson, 43 Van Natta 1505 (1991). Thus, Dr. Catlin's opinion does not support a finding that claimant suffered a pathological worsening or a new occupational disease at SAIF's insured.

Dr. Becker first examined claimant on September 21, 1990. On November 12, 1991, he concurred with a conversation summary prepared by Liberty's counsel. (Ex. 50). He concurred that: (1) claimant had no synovitis in her upper extremity joints on September 21, 1990; and (2) on December 20, 1990 he diagnosed flexor tenosynovitis and left tennis elbow, conditions that claimant did not have when he first examined her. (Ex. 50-1). He concurred that these two "new" conditions represented a worsening of her condition. Id. We do not find that Dr. Becker's opinion establishes a new occupational disease or a pathological worsening of claimant's compensable occupational disease.

Earlier, Dr. Becker opined that the left tennis elbow is part of the overuse syndrome in claimant's upper extremities. (Ex. 44). However, he was apparently unaware that claimant had previously suffered from left tennis elbow while under the Liberty claim. Although Dr. Catlin sent Dr. Becker selected chart notes, it is not clear that he received the medical records which indicate that claimant previously suffered from left tennis elbow. (Ex. 16, 31). On this basis, Dr. Becker's opinion does not establish that the recurrence of left tennis elbow is a new occupational disease or a pathological worsening of the compensable occupational disease.

Regarding the lack of synovitis on September 21, 1990 and the diagnosis of flexor tenosynovitis on December 20, 1990, Dr. Becker also noted on December 20, 1990 that claimant had no evidence of synovitis. (Ex. 45). In that same examination, Dr. Becker noted that claimant had "evidence of some mild flexor tenosynovitis in the right fourth finger." Id. However, on November 10, 1989, Dr. Catlin noted that she would refer claimant to an orthopedic surgeon regarding claimant's tenosynovitis of the right fourth finger. (Ex. 1-11). Thus, like left tennis elbow, claimant previously suffered from tenosynovitis in her right fourth finger while under the Liberty claim. Dr. Becker was apparently unaware of that history. Therefore, his diagnosis of flexor tenosynovitis in December 1990, without further explanation, does not establish that the recurrence of this condition represented a "new condition" or a pathological worsening.

Both Liberty and SAIF denied claimant's claim for CTS. (Exs. 40, 49). Although claimant established that she continues to suffer from bilateral upper extremity overuse syndrome, she did not

establish that CTS is part of this syndrome or that she has CTS. While the claim was under Liberty, claimant was diagnosed with possible CTS. After claimant began to work for SAIF's insured, Dr. Catlin referred her to Dr. Becker for a consultation regarding her upper extremity symptoms. Dr. Becker initially opined that claimant might have CTS, noting that her negative nerve testing did not rule it out. (Ex. 33). However, Dr. Becker ultimately concluded that claimant did not have CTS because she did not respond to cortisone injections and did not manifest worsening signs of CTS over time. (Exs. 34, 36, 44, 45). No other medical opinion addresses CTS. Therefore, although claimant suffers wrist pain relating to the compensable bilateral upper extremity overuse syndrome, she has not established that she has CTS.

On this record, claimant has not established that she sustained a new occupational disease during her employment at SAIF's insured.

Aggravation

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

We find that Dr. Catlin's November 13, 1991 report establishes that the major cause of the worsening of claimant's bilateral upper extremity overuse syndrome was her work as a cook and baker prior to working at SAIF's insured. (Ex. 51-2). This opinion exceeds claimant's burden of establishing that her current condition is materially related to the compensable condition. Robert E. Leatherman, 43 Van Natta 1678 (1991).

Here, at the time of the May 14, 1990 Determination Order, claimant was released to regular work. Dr. Boughal, consulting D.O., had restricted claimant to modified work only through February 12, 1990. (Ex. 23). Furthermore, Dr. Boughal concurred with a March 31, 1990 IME report which found that claimant could return to her regular employment without restrictions. (Exs. 24-3, 25). In addition, claimant's left tennis elbow and right ring trigger finger conditions were asymptomatic after her claim was closed. In June 1990, claimant returned to her regular work at the at-injury restaurant, although it was under new ownership. Due to pain in her upper extremities, she quit after about a week. Later in June 1990, claimant began working for SAIF's insured, which she hoped would involve lighter work. However, she quit this job in December 1990 due to upper extremity pain. On November 13, 1991, Dr. Catlin opined that claimant should avoid repetitive use of her arms and heavy lifting, limitations which Dr. Catlin felt would rule out a return to claimant's regular work as a cook or baker. (Ex. 51-2). Accordingly, we find that claimant has established an increased loss of use or function of her upper extremities.

As noted above, we find that Dr. Catlin's reliance on claimant's complaints of increased pain establish medical evidence of a worsening supported by objective findings. ORS 656.273(1). In addition, the recurrence of the left tennis elbow provides further objective medical evidence of a worsening. Furthermore, because the May 14, 1990 Determination Order awarded no permanent disability, claimant need not establish that her worsening is more than waxing and waning of symptoms contemplated by the previous permanent disability award. ORS 656.273(8).

We, therefore, find that claimant has proven that her condition has worsened since the last arrangement of compensation. Accordingly, claimant has proven compensability of her claim for aggravation.

Responsibility

In cases in which an accepted injury is followed by an increase in disability during employment with a later carrier, responsibility presumptively rests with the original carrier, unless the claimant sustains an actual, independent compensable injury or occupational disease during the subsequent work exposure. ORS 656.308(1); Ricardo Vasquez, 43 Van Natta 1678 (1991); Donald C. Moon, 43 Van Natta

2595 (1991). Thus, as the last carrier against which claimant had accepted bilateral overuse condition and right ring trigger finger conditions, Liberty remains responsible unless it establishes that claimant's work activities with SAIF's insured were the major contributing cause of a new occupational disease or a pathological worsening of claimant's bilateral upper extremity condition. See Rodney H. Gabel, 43 Van Natta 2662 (1991).

We have above found that the opinions of Drs. Catlin and Becker do not establish a new occupational disease, a new injury, or a pathological worsening of claimant's compensable occupational disease as the result of claimant's work activities at SAIF's insured. There is no other medical evidence to support a new injury or occupational disease. Accordingly, we find that Liberty has failed to establish that claimant sustained an actual new injury or occupational disease with SAIF's insured. Therefore, pursuant to ORS 656.308(1), responsibility remains with Liberty.

Penalties

Claimant cross-requested review of the Referee's order, arguing that, if the Board finds Liberty responsible for claimant's condition, it should assess penalties against Liberty for its allegedly unreasonable denial. Because we find Liberty responsible, we address claimant's cross-request.

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).

On December 4, 1990, Liberty denied that claimant's current condition which involved bilateral upper extremity overuse syndrome and possible bilateral CTS was related to her accepted conditions with Liberty's insured. (Ex. 40). Because we have found the possible bilateral CTS not compensable, it was not unreasonable to deny that condition. Furthermore, the medical evidence available at the time of Liberty's denial of claimant's current condition indicated that her work at SAIF's insured contributed to her condition. Although we have found that this evidence was not sufficient to establish a pathologic worsening necessary to shift responsibility, we find that it was sufficient to create a legitimate doubt as to Liberty's responsibility for claimant's current condition. Therefore, we do not find Liberty's denial of claimant's current condition to be unreasonable.

Attorney Fees - Hearings/Board

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 \$3,000 (as previously awarded by the Referee) and on review is \$750, to be paid by Liberty. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's counsel's respondent's brief), the complexity of the issue, and the value of the interest involved. We further note that claimant's attorney is not entitled to a fee for services devoted to the unsuccessful cross-request.

ORDER

The Referee's order dated January 8, 1992 is reversed in part and affirmed in part. The SAIF Corporation's denial is reinstated and upheld. Liberty Northwest Insurance Corporation's denial is set aside and the claim is remanded to Liberty for processing according to law. Liberty is responsible for the Referee's \$3,000 attorney fee award. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of \$750, to be paid by Liberty.

In the Matter of the Compensation of
MARY J. McKENZIE, Claimant
WCB Case No. 90-16618
ORDER ON REVIEW
Galton, et al., Claimant Attorneys
Terrall & Associates, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Poland's order that: (1) upheld the self-insured employer's denial of claimant's psychological condition; (2) affirmed a July 26, 1990 Determination Order in its entirety; and (3) declined to assess penalties or attorney fees for the employer's allegedly unreasonable denial. On review, the issues are compensability, premature closure, extent of permanent partial disability, and penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND REASONING

Compensability

Claimant seeks compensation for a disabling psychological condition, which she contends is a consequence of her compensable injury. The Referee concluded that the condition was not compensable under ORS 656.005(7)(a)(A), because claimant had failed to prove that the injury was the major contributing cause of the alleged consequential condition.

On review, claimant argues that the Referee erred in applying the major contributing cause standard of ORS 656.005(7)(a)(A). Citing ORS 656.202, she contends that the compensability of her condition must be analyzed under the law in effect at the time of her injury, under which she is only required to prove that the condition was caused in material part by the compensable injury.

Claimant's reliance on ORS 656.202 is misplaced. 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 Workers' Compensation Law as amended by the 1990 legislature. Ida M. Walker, 43 Van Natta 1402 (1991). Oregon Laws, chapter 2, section 54 provides, in part:

"[T]his 1990 Act becomes operative July 1, 1990, and notwithstanding ORS 656.202, the 1990 Act applies to all claims existing or arising on and after July 1, 1990, regardless of the date of injury[.]" (Emphasis supplied).

The Referee applied the correct standard. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

In the alternative, claimant argues that the Referee erred in evaluating the medical evidence. Two expert medical opinions were submitted in this matter. Dr. Fleming, a psychologist who has treated claimant since October 1989, opined that claimant's compensable injury was the major contributing cause of her psychological condition, which he diagnosed as a moderately severe anxiety and depressive neurosis. Dr. Parvaresh, a psychiatrist who examined claimant in June 1990, opined that claimant had a variety of psychological problems that they preexisted and were unrelated to her compensable injury.

When there is a dispute between medical experts, we tend to give greater weight to the conclusions of the treating physician, unless there are persuasive reasons not to do so. Taylor v. SAIF, 75 Or App 583 (1985). In this case, claimant's treating physician had the opportunity to see her on at least 19 occasions over a period of almost two years. He had a much better opportunity to evaluate claimant's condition than Dr. Parvaresh, who examined claimant on only one occasion. Moreover, contrary to Dr. Parvaresh's opinion, there is no evidence that claimant suffered from previous psychological problems prior to her compensable injury that resulted in a C5-6 surgical fusion followed by continuing pain.

We accept the opinion of Dr. Fleming, which we find well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). Accordingly, we conclude that claimant has established the compensability of her psychological condition and set aside the employer's denial.

Premature Closure

The Referee concluded that claimant's claim had not been prematurely closed by the July 26, 1990 Determination Order, because there was not a reasonable medical expectation that treatment or the passage of time would improve her physical condition. While we agree with that conclusion, the Referee did not address claimant's psychological condition, which we have now found compensable. Because claimant must be medically stationary from all conditions resulting from the compensable injury before her claim may be closed, we consider her psychological condition on review. Kociemba v. SAIF, 63 Or App 557 (1983).

Claimant began treating with Dr. Fleming for her psychological condition in October 1989. Although Fleming reported on two occasions that claimant was responding well to psychotherapy, the treatments were terminated in June 1990 after Dr. Parvaresh reported that claimant was not in need of any treatment and that there was nothing from a psychiatric standpoint to prevent claim closure. Fleming disagreed with Parvaresh's opinion and, on June 27, 1990, reported that claimant was clearly in need of further psychological assistance.

After our review of the record, we conclude that the evidence establishes that claimant was not medically stationary as of the date of closure with regard to her psychological condition. While Dr. Fleming's opinion contains no explicit statement in so many words, magic words are not necessary and we infer from his report that, at the time of closure, there was a reasonable medical expectation that further treatment would improve her psychological condition. See Austin v. SAIF, 48 Or App 7 (1980). We are not persuaded by the contrary opinion of Dr. Parvaresh, because its premise--that claimant does not have a psychological condition--is contrary to the law of the case and, as a legal matter, is wrong. See Kuhn v. SAIF, 73 Or App 768 (1985).

Penalties and Attorney Fees--Unreasonable Denial

Claimant finally argues that the Referee erred in failing to award either a penalty or assessed attorney fee for the employer's unreasonable delay in denying her claim. The initial diagnosis of claimant's psychological condition was made by Dr. Fleming in his letter to the employer dated November 11, 1989. The employer did not deny the claim, however, until July 17, 1990. Because the employer has offered no explanation for its delay, we find it unreasonable. See Lester v. Weyerhaeuser, 70 Or App 307 (1984). For its unreasonable delay, the employer may be assessed a penalty under ORS 656.262(10)(a) based on any amount of compensation due at the time of the denial. See Wacker Siltronic Corp. v. Satcher, 91 Or App 654 (1988). However, there is no persuasive evidence that any amounts of compensation were then due; the employer evidently paid temporary disability and medical benefits up to the date of its denial. Accordingly, there is no basis for assessing a penalty.

Nonetheless, ORS 656.382(1) provides for an assessed attorney fee when an employer unreasonably resists the payment of compensation, even if there are no amounts of compensation then due upon which to base a penalty. See Nicolasa Martinez, 43 Van Natta 1638 (1991). We find the employer's unexplained delay in responding to claimant's claim had the effect of delaying the payment of compensation. Therefore, we assess an attorney fee pursuant to ORS 656.382(1). Richard I. Stevenson, 43 Van Natta 1883 (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 is \$400, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue, the complexity of the issue and the value of the interest involved.

Attorney Fee--At Hearing and on Board Review

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

Finally, since the Determination Order has been set aside as premature, claimant's attorney is awarded 25 percent of the increased compensation created by our rescission of the Determination Order, not to exceed \$3,800. OAR 438-15-055(1); Dianne M. Bacon, 43 Van Natta 1930 (1991). This fee is payable from claimant's increased compensation.

ORDER

The Referee's order dated January 27, 1992 is reversed. The employer's denial of claimant's psychological condition is set aside, and the claim is remanded to the employer for further processing according to law. The July 26, 1990 Determination Order is set aside as premature. Claimant's attorney is awarded a \$400 attorney fee for SAIF's unreasonable denial. For services at hearing and on Board review concerning the compensability issue, claimant's attorney is also awarded an assessed fee of \$3,000, to be paid by the employer. Claimant's attorney is also awarded an out-of-compensation fee equal to 25 percent of the increased compensation created by our rescission of the Determination Order, not to exceed \$3,800.

November 17, 1992

Cite as 44 Van Natta 2304 (1992)

In the Matter of the Compensation of
RANDY M. MITCHELL, Claimant
WCB Case No. 91-12737
ORDER ON REVIEW (REMANDING)
Karen M. Werner, Claimant Attorney
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Myzak's 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

We adopt the Referee's findings of fact with the following supplementation. The record does not contain claimant's request for reconsideration.

CONCLUSIONS OF LAW AND OPINION

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.

Claimant argues that the Referee should not have dismissed his hearing request on the basis of the SAIF Corporation's motion to dismiss. Claimant asserts that, because the SAIF Corporation did not object to the Determination Order, it should not be allowed to use the provisions regarding requests for medical arbiters defensively. We agree with claimant's argument. However, we find that the record is incompletely developed and we remand.

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), §54(3). The Director's rules in effect at the time of the September 6, 1991 Order on Reconsideration are applicable. Former OAR 436-30-003(4) (WCD Admin. Order 33-1990, effective December 26, 1990).

We have previously held that we lack jurisdiction to consider a request for hearing concerning objections to a Notice of Closure or Determination Order before the reconsideration process established by ORS 656.268(5) through (7) is completed. See Lorna D. Hilderbrand, 43 Van Natta 2721, 2722 (1991). Moreover, we also have held that an Order on Reconsideration is invalid, and we therefore lack jurisdiction to consider a request for hearing concerning the Order on Reconsideration, if the basis for objection to the Notice of Closure or Determination Order is disagreement with the impairment findings used in rating the worker's disability, and the Department fails to appoint a medical arbiter and submit the arbiter's findings for reconsideration. See ORS 656.268(7); Olga I. Soto, 44 Van Natta 697, 700 (1992).

In addition, we have found that, in determining the validity of an Order on Reconsideration, we distinguish between a party who objects to the actual findings of impairment by the attending physician, and a party who objects to the application or interpretation of the attending physician's impairment findings to determine the award of scheduled permanent disability. Doris C. Carter, 44 Van Natta 769, 770 (1992). Where a party does not contest the medical findings of impairment, referral to an arbiter or panel of arbiters is not required. Id. Likewise, applying the reasoning used in Doris C. Carter, *supra*, we find that nothing precludes a party from withdrawing its previous objection to the impairment findings and thereby waiving the requirement of referral to an arbiter. Here, the question presented is whether a party that does not object to the medical findings used in the Determination Order may have the Order on Reconsideration declared invalid due to the Director's failure to appoint a medical arbiter.

ORS 656.268(4)(e) provides that "[i]f a worker objects to the notice of closure, the worker first must request reconsideration by the department under this section." ORS 656.268(5) provides, in pertinent part, that "[i]f the worker, the insurer or self-insured employer objects to a determination order issued by the department, the objecting party must first request reconsideration of the order." 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 added).

Thus, either party may object to a Determination Order and request reconsideration. However, it is the objecting party which frames the basis of its objection and thereby determines whether appointment of a medical arbiter pursuant to ORS 656.268(7) is required. Because the requirement for appointment of a medical arbiter is limited by statute to a particular objection to a Notice of Closure or Determination Order, it is the objecting party who has the right to enforce that requirement. In other words, a party that does not object to a Determination Order or Notice of Closure on the basis of a disagreement with the impairment used in rating the worker's disability may not use the statutes defensively to have an Order on Reconsideration declared invalid for failure to appoint a medical arbiter, unless the party that had objected joins in the motion.¹

Here, there is no evidence that SAIF objected to the Determination Order or requested a reconsideration of that order on any basis. Therefore, we conclude that claimant's hearing request may not be dismissed and the Order on Reconsideration may not be found invalid solely based on SAIF's motion to dismiss due to the Director's failure to appoint a medical arbiter.

The record does not contain a copy of claimant's request for reconsideration. Therefore, claimant's basis for his objection to the Determination Order is not clear. In any event, even if claimant objected to the impairment findings used in determining his impairment, he may withdraw this objection and thereby waive his right to a medical arbiter. Brenton R. Kusch, 44 Van Natta 2222 (1992). After a careful review of the record and claimant's brief, we are unable to determine either the basis for claimant's objection to the Determination Order or whether claimant withdrew any objection to the

¹ Additionally, the Director's failure to appoint a medical arbiter does not render the ensuing Order on Reconsideration void ab initio. Brenton R. Kusch, 44 Van Natta 2222 (1992). Rather, it results in an order which may be voided by a party which the mandatory provision was intended to protect, which in this case is claimant as SAIF did not request reconsideration. Id.

impairment findings used in determining his impairment or was given the opportunity to do so at whatever hearing was held on SAIF's motion.² In this regard, we note that, although claimant argues in his appellant's brief that it was improper to dismiss his hearing request and find the Order on Reconsideration invalid based on SAIF's motion, he also argues that his impairment rating should be increased based on his testimony at hearing and evidence from a subsequent attending physician. However, 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. Conner, 43 Van Natta 2799 (1992).

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 and given our uncertainty about whether claimant wishes to withdraw or has withdrawn any objection to the impairment findings used to determine his disability, we conclude that the record is insufficiently developed.

Accordingly, the Referee's order dated January 14, 1992 is vacated. This matter is remanded to Referee Myzak 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).

If claimant did not object to impairment findings in his request for reconsideration, the Referee may go forward and determine claimant's disability based on the findings of the attending physician at claim closure. Doris C. Carter, *supra*. Moreover, if claimant initially requested reconsideration based on an objection with the impairment findings used in determining his disability and now withdraws that objection, thereby waiving his right to referral to a medical arbiter, the Referee may go forward and determine claimant's disability based on the findings of the attending physician at claim closure. Brenton R. Kusch, *supra*; Dennis E. Conner, *supra*. Finally, if claimant initially requested reconsideration based on an objection to the impairment findings and declines to withdraw his objection, the Referee should consider the Board's reasoning in Olga I. Soto, *supra*.

ORDER

The Referee's order dated January 14, 1992 is vacated. This matter is remanded to Referee Myzak for further proceedings consistent with this order.

² Apart from the inference to SAIF's motion in claimant's appellant's brief, we do not find any written or recorded record of SAIF's motion in the case filed, nor does the record include any transcript of procedures on such a motion. SAIF does not deny that it made a motion to dismiss claimant's hearing requests, and thus, we assume that the motion was made of the official record. For the reasons indicated here and above, the record is inadequate for review.

November 17, 1992

Cite as 44 Van Natta 2306 (1992)

In the Matter of the Compensation of
IOLA W. PAYNE-CARR, Claimant
 WCB Case Nos. 90-05670 & 91-09641
 ORDER ON REVIEW
 Peter O. Hansen, Claimant Attorney
 Roberts, et al., Defense Attorneys

Reviewed by Board Members Westerland and Gunn.

Claimant requests review of Referee Spangler's order that affirmed a Director's order finding that proposed right knee surgery is not reasonable and necessary. See ORS 656.327(2). In her brief, claimant requests remand, contending that the Referee erred in refusing to allow her to develop the record at hearing. On review, the issues are scope of review, substantial evidence and remand. We deny the motion to remand and affirm.

On the merits, we adopt the order of the Referee, with the following supplementation.

Claimant does not contend that the Director lacked authority to decide, in the first instance, whether the claimed medical services are reasonable and necessary. Instead, claimant argues, that in confining the scope of his review to the record before the Director, the Referee deprived claimant of the right to a full evidentiary hearing on the medical services issue.

ORS 656.327(2) provides in pertinent part, that "[r]eview of the [Director's] order shall be as provided in ORS 656.283 * * * except that the order of the director may be modified only if the order is not supported by substantial evidence in the record." (Emphasis added). The question is what does this language mean.

Before the 1990 amendments, medical treatment disputes were handled by the Board and its Hearings Division like any other matter concerning a claim. The Hearings Division had original jurisdiction. Board review was de novo. The Director was not involved.

The 1990 amendments changed all that. Now, the Director has original jurisdiction. Stanley Meyers, 43 Van Natta 2643 (1991). Although the party adversely affected by the Director's order may request a hearing under ORS 656.283, amended ORS 656.327(2) states that the Director's order may be modified "only if the order is not supported by substantial evidence in the record." We find the language plain and unambiguous. Consistent with its purpose to have medical treatment disputes decided by physicians rather than Referees, the legislature has clearly confined the Referee's scope of review to the record before the Director, and authorized the Referee to modify the Director's order only if the order is not supported by substantial evidence in the record. Thus, "the record" means the record before the Director. Any other conclusion would not comport with the statute's plain language. Furthermore, an order from this Board authorizing Referees to consider evidence outside that record would revive the state of affairs which had existed before the 1990 amendments, and would defeat the legislature's purpose to have these matters decided by physicians rather than referees.

In reaching this conclusion, we contrast "the record" in hearings conducted under ORS 656.327(2) with "the record" in hearings held pursuant to ORS 656.283(2). A hearing concerning a Director's order regarding vocational assistance (ORS 656.283(2)) is designed to determine the historical facts relevant to the dispute. Lasley v. Ontario Rendering, 114 Or App 543, 547 (1992). Since no "record" has been prepared in advance of the hearing in such appeals, it is the responsibility of the Referee when reviewing a Director's order to "make a record." Richard A. Colclasure, 42 Van Natta 2454 (1990).

In contrast, ORS 656.327(2) expressly provides that a Director's order regarding medical treatment may be modified only if the order is not supported by substantial evidence in the record. See also OAR 438-17-010(2). In accordance with this statute, the Board's rules further require the Director to provide the Board's Hearings Division with a certified copy of the entire record, including an index of all items contained in the record. OAR 438-17-020(1). In light of these statutory and administrative directives, it is apparent that hearings of Director's orders issued pursuant to ORS 656.327(2) are based on records developed before the Director.

Finally, claimant requests remand, contending that the Referee erred in refusing to allow claimant to develop the record at hearing. However, inasmuch as we agree with the Referee's conclusion that the Director's order is supported by substantial evidence in the record, we do not find that the record has been improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5). Accordingly, the request for remand is denied.

ORDER

The Referee's order dated February 21, 1992 is affirmed.

In the Matter of the Compensation of
STANLEY H. RANDOLPH, Claimant
WCB Case No. 91-09128
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Brazeau's order that affirmed an Order on Reconsideration award of no scheduled permanent partial disability. In its respondent's brief, the insurer seeks review of that portion of the order that awarded claimant 37 percent (118.4 degrees) unscheduled permanent partial disability, whereas an Order on Reconsideration had awarded none. On review, the issue is extent of unscheduled and scheduled permanent partial disability.

We affirm and adopt the Referee's order.

Claimant has prevailed against the insurer's request for a reduction of the Referee's award of unscheduled permanent disability. ORS 656.382(2); Kordon v. Mercer Industries, 94 Or App 582 (1989). Under such circumstances, ORS 656.382(2) authorizes the assessment of a reasonable fee for claimant's attorney's services rendered on review, provided there is some evidence of legal representation. See Shirley M. Brown, 40 Van Natta 879 (1988). Although claimant's attorney declined to file a separate brief in response to the employer's argument, she did submit a letter and indicated that claimant intended to rely on the opening brief. In upholding the award of unscheduled permanent disability, we have relied, in part, on the summary of the facts contained in that opening brief. Accordingly, notwithstanding the fact that claimant filed no respondent's brief, we find the work performed by claimant's attorney on review, as represented by the opening brief, should be compensated. See Dawn M. Von Poppenheim, 42 Van Natta 2660 (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 concerning the extent of unscheduled disability issue is \$150, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue, the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 21, 1992 is affirmed. For services on Board review concerning the extent of claimant's unscheduled permanent partial disability, claimant's attorney is awarded an assessed fee of \$150, to be paid by the insurer.

November 18, 1992

Cite as 44 Van Natta 2308 (1992)

In the Matter of the Compensation of
WILLIAM H. BACHMAN, Claimant
WCB Case Nos. 91-05331, 90-19312 & 90-19783
ORDER ON REVIEW
Hedges & Mitchell, Claimant Attorneys
Roberts, et al., Defense Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Moller and Neidig.

Employers Insurance of Wausau requests review of that portion of Referee Hoguet's order that set aside its denial of claimant's aggravation claim for his low 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

On review, Wausau does not challenge the Referee's conclusions regarding the issue of responsibility. We agree that the evidence does not establish that claimant sustained a new compensable injury while Travelers Insurance Company was on the risk. ORS 656.308(1); Ricardo Vasquez, 43 Van Natta 1678 (1991). Accordingly, we analyze the compensability of claimant's aggravation claim with Wausau.

Aggravation

The Referee concluded that claimant had established that the 1989 compensable injury was a material contributing cause of his worsened condition and current need for treatment and surgery. The Referee further concluded that claimant had established the remaining elements required to establish a compensable aggravation claim for his low back condition. We agree. We adopt the Referee's Conclusions of Law and Opinion on the issue of compensability of claimant's aggravation claim, and we add the following supplementation.

On review, Wausau contends that claimant's aggravation claim is not compensable because his worsened condition is attributable to an off-work injury, rather than to his accepted 1989 injury. Wausau argues that the Referee should have relied upon the opinion of Dr. Gancher, an independent medical examiner who opined that claimant's worsened condition was due to either the off-work camping incident or to scar tissue from claimant's 1971 surgery.

We agree, however, that the Referee properly deferred to the opinion of Dr. Bachhuber, claimant's treating physician since 1971. Furthermore, we decline to rely upon the opinion of Dr. Gancher who reported that claimant's need for surgery and possible disc problems resulted from the "July 1990 lifting injury." As claimant notes in his brief, the July 1990 camping incident did not involve any lifting. Rather, claimant's low back pain became severe when he bent over to pick up an awning stake. (Tr. 36). Additionally, in June 1990, when claimant experienced back pain at work, he was pushing and pulling a pump base, rather than lifting it. (Tr. 10).

In addition, we agree with the Referee that, due to the inconsistencies in Dr. Gancher's testimony, his opinion does not support a finding that an off-the-job injury was the major contributing cause of claimant's condition. See Roger D. Hart, 44 Van Natta 2189 (1992) (if an employer denies an aggravation claim on the grounds that an off-the-job injury is the major contributing cause of the worsened condition; as the proponent of that fact, the employer has the burden of proving it). We are also not persuaded by Dr. Gancher's opinion regarding claimant's scar tissue, and we defer to the opinion of Dr. Bachhuber, who both treated claimant over a long period of time and performed his most recent back surgery.

Under the circumstances, we agree with the Referee that claimant has established a compensable aggravation claim. We, therefore, affirm the Referee on this issue.

Claimant is entitled to an assessed attorney fee for prevailing against Wausau's request for review on the issue of compensability. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is \$1,000, to be paid by Wausau. 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 12, 1991 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of \$1,000, to be paid by Employers Insurance of Wausau.

In the Matter of the Compensation of
DANNIE W. CRAWLEY, Claimant
Own Motion No. 91-0127M
OWN MOTION ORDER
Dennis Henninger, Claimant Attorney
David Runner, Assistant Attorney General

The SAIF Corporation has requested reconsideration of our prior orders in this matter that denied its request for reimbursement from the Reopened Claims Reserve. We deny SAIF's motion.

In February 1991, SAIF petitioned the Board for reimbursement authorization for temporary disability benefits voluntarily paid from February 8, 1987 through May 25, 1990. On March 15, 1991, we issued an Own Motion Order in which we denied SAIF's petition on the basis that the claim reopening was prior to January 1, 1988, the effective date of the establishment of the Reopened Claims Reserve. Dannie W. Crawley, 43 Van Natta 568 (1991). Thereafter, SAIF petitioned the Court of Appeals for judicial review.

On August 22, 1991, we withdrew our March 15, 1991 order for purposes of reconsideration. On August 28, 1991, we issued an Own Motion Order on Reconsideration, continuing to adhere to our previous decision denying SAIF's request for reimbursement. Dannie W. Crawley, 43 Van Natta 1796 (1991). Thereafter, the Court of Appeals proceeded with its review of SAIF's petition for judicial review.

On May 13, 1992, the court concluded that it lacked jurisdiction over SAIF's appeal and consequently dismissed SAIF's petition. SAIF v. Crawley, 113 Or App 152 (1992). Citing ORS 656.278(3) and International Paper Co. v. Wright, 80 Or App 444, 447 (1986), the court reasoned that since our order did not increase claimant's compensation award, it was without authority to consider SAIF's petition.

Inasmuch as the court dismissed SAIF's petition for review, and that dismissal is final, we have no authority to reconsider our prior orders insofar as such reconsideration requests are presented within the context of this particular case number. Accordingly, we deny SAIF's request for reconsideration.

Parenthetically, we note that we have treated SAIF's motion as a new request for Own Motion relief. We have assigned the request WCB Case No. 92-0619M and this date have issued an Own Motion order in that matter.

IT IS SO ORDERED.

November 18, 1992

Cite as 44 Van Natta 2310 (1992)

In the Matter of the Compensation of
DANNIE W. CRAWLEY, Claimant
Own Motion No. 92-0619M
OWN MOTION ORDER
Dennis Henninger, Claimant Attorney
David Runner, Assistant Attorney General

The SAIF Corporation has requested reconsideration of our prior orders in WCB Case No. 91-0127M that denied its request for authorization for reimbursement from the Reopened Claims Reserve. This date we have denied SAIF's request. Notwithstanding our decision in that case, we also treat SAIF's motion as a new request for Own Motion relief.

In SAIF v. Holmstrom, 113 Or App 242 (1992), the court held that the Board lacks authority to either grant or deny reimbursement from the Reopened Claims Reserve. The court reasoned that, although the Board may authorize the payment of temporary disability compensation, the authority to grant or deny reimbursement from the Reserve rests with the Director. Id.

In its motion, SAIF does not ask that we reopen claimant's claim. In fact, SAIF has voluntarily reopened the claim. Rather SAIF seeks retroactive authorization for temporary disability that it voluntarily paid to claimant from February 8, 1987 through May 25, 1990.

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.

Here, claimant's compensable condition worsened and he underwent surgery on February 8, 1987. Inasmuch as we may authorize the payment of temporary disability compensation, and claimant meets the criteria set out in ORS 656.278(1), we retroactively authorize the payment of temporary disability compensation which SAIF has already paid from February 8, 1987 through May 25, 1990.

IT IS SO ORDERED.

November 18, 1992

Cite as 44 Van Natta 2311 (1992)

In the Matter of the Compensation of
JOSEPH F. PRUSASKI, Claimant
WCB Case No. 91-13830
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Brazeau.

The self-insured employer requests, and claimant cross-requests, review of Referee Bethlahmy's order that increased claimant's unscheduled permanent disability award for a left shoulder injury from 21 percent (67.2 degrees), as awarded by Order on Reconsideration, to 30 percent (96 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

The parties do not challenge, and we therefore adopt, the Referee's findings and conclusions concerning the left shoulder impairment values. Additionally, we adopt the Referee's findings and conclusions concerning the values for the nonmedical factors of age and adaptability.

The Referee awarded claimant an impairment value of 10 percent for a class II psychological condition. The employer contends that the medical evidence does not support that award.

Because claimant became medically stationary after July 1, 1990, and his claim was closed by Determination Order on March 14, 1991, the applicable standards for rating his permanent disability are found in WCD Admin. Order 6-1988, as amended by WCD Admin. Orders 15-1990 and 20-1990 (Temp.). See OAR 436-35-003(2).

Dr. Soule, the attending psychiatrist, declared claimant psychologically stationary on December 19, 1990, with continuing symptoms of regular nightmares, disruptive sleep pattern, and anxiety attacks that manifest with tachycardia (excessively rapid heart rate), restlessness and circular ruminative thinking. (Ex. 50). Dr. Soule later reported that claimant left treatment in February 1991, but continued to have residual post-traumatic symptoms requiring medication. (Ex. 54-2).

Based on Dr. Soule's report of sleep disturbances and anxiety attacks, we agree with the Referee that claimant has a class II psychological disorder consisting of anxiety and depressive reactions. See

former OAR 436-35-400(5)(b)(A), (B) (WCD Admin. Order 15-1990). We further find that the severity of the disorder is minimal. Therefore, we conclude that claimant is entitled to an impairment value of 6 percent for the psychological condition. See former OAR 436-35-400(5)(b). We modify the Referee's award accordingly.

On review, claimant argues that he is entitled to an additional 5 percent impairment value for a chronic psychological condition. We disagree. Former OAR 436-35-320(5) provides that a worker is entitled to benefits for unscheduled chronic condition impairment where the medical evidence establishes that the worker is unable to repetitively use a body area due to a chronic condition. WCD Admin. Order 15-1990. "Body area" is expressly limited to either the cervical/upper back/shoulders area or the low back/hips area. *Id.* Inasmuch as that definition does not include a psychological condition, claimant is not entitled to an unscheduled chronic condition impairment. Thus, we find that claimant is entitled to a value of 6 percent for the impairment factor.

Finally, we note that the Referee did not specifically address the education factor in her order; therefore, we address it here. Claimant has earned a high school diploma and performed the job of high school teacher for one year (DOT #091.227-010). Because that job has a specific vocational preparation (SVP) level of 7, claimant is given a value of 1 for the education factor. Former OAR 436-35-300(4) (WCD Admin. Order 15-1990).

We now proceed to calculate claimant's unscheduled permanent disability award. Adding the age value (1) to the education value (1) yields a total of 2. That value is then multiplied by the adaptability value (1), resulting in a product of 2. Turning to the impairment values, we combine the values for lost ranges of motion (2 percent), surgery (5 percent), loss of strength (10 percent), chronic shoulder condition (5 percent), and psychological condition (6 percent) for a total impairment value of 25 percent. When that value is added to the 2 percent value for the nonmedical factors, the total unscheduled permanent disability award is 27 percent.

ORDER

The Referee's order dated February 3, 1992 is modified. In lieu of the Referee's unscheduled permanent disability award, and in addition to the Order on Reconsideration award of 21 percent (67.2 degrees) unscheduled permanent disability, claimant is awarded 6 percent (19.2 degrees) unscheduled permanent disability, giving him a total unscheduled permanent disability award of 27 percent (86.4 degrees). Claimant's attorney fee award is adjusted accordingly.

November 18, 1992

Cite as 44 Van Natta 2312 (1992)

In the Matter of the Compensation of
GRACE M. RANDALL, Claimant
Own Motion No. 92-0415M
OWN MOTION ORDER ON RECONSIDERATION
Welch, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

On October 1, 1992, claimant requested reconsideration of our September 29, 1992 Own Motion Order in the above-captioned case. In order to allow sufficient time to consider the motion for reconsideration, we abated our order on October 13, 1992. After reviewing claimant's motion and further reviewing the matter, we continue to adhere to our prior order based on the following reasoning.

Claimant has not worked since her 1978 compensable injury. Her compensable condition was evaluated at a March 1985 hearing concerning her appeal from a Determination Order. At that hearing, claimant sought permanent total disability. In declining to grant claimant's request, the Referee found that claimant was capable of performing gainful employment, and had not established that she was willing to seek work or had made reasonable efforts to obtain work. The Referee's order was affirmed by the Board. In affirming the Referee, the Board agreed that claimant had not established that she was

willing to seek work. The Board also noted that it would not be futile for claimant to seek work. Thereafter, the Court of Appeals affirmed the Board's order without opinion.

In 1987, claimant requested Own Motion relief in the form of temporary disability benefits. However, the Board denied claimant's request for relief on the basis that she was not in the work force at the time of the alleged worsening.

Claimant contends that the Board erred in concluding that she was not in the work force at the time of her most recent hospitalization. In support of this contention, claimant has submitted a report from Dr. Misko, her attending physician. In that letter, Dr. Misko states:

"Since I am not certain what [claimant] was qualified for, I cannot really be very accurate about whether [claimant] could have been working prior to her sudden onset of pain in September 1991. Certainly from the size of [claimant's] ruptured disc, [claimant] would not have been able to have been in the work force as of September 1991. Assuming that [claimant] had the weakness of her hip flexors and hip extensors and hamstrings at that time, when I examined her in May, [claimant] certainly was unable to work. This was on May 11, 1992. Whether or not this [claimant] could have been employed prior to that, I am not certain."

Although Dr. Misko seems to indicate that claimant was unable to work in September 1991, he is uncertain with regards to claimant's ability to work in May 1991, the time of claimant's disability. Moreover, Dr. Misko does not explain why it is now futile for claimant to make reasonable efforts to seek work, when in 1985 and again in 1987, the Board found that it would not be futile for claimant to make such efforts. Under these circumstances, we find no persuasive reason to depart from our prior determinations that claimant's compensable condition did not make it futile for her to make reasonable efforts to obtain employment. See Wausau Ins. v. Morris, 103 Or App 270 (1990). Therefore, we continue to find that claimant was not in the work force at the time of her May 1991 worsening.

Accordingly, as supplemented herein, we adhere to and republish our September 29, 1992, order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

November 18, 1992

Cite as 44 Van Natta 2313 (1992)

In the Matter of the Compensation of
JON A. ROGERS, Claimant
WCB Case No. 91-07263
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Lafky & Lafky, Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Neidig and Moller.

The noncomplying employer requests review of Referee Baker's order that set aside the SAIF Corporation's denial, on its behalf, of claimant's right knee condition. In his respondent's brief, claimant contends that the employer has not served SAIF with either notice of its request for review or with a copy of its appellant's brief. Claimant moves for dismissal of the employer's request for review, and alternatively moves to strike the employer's appellant's brief. In its brief, the employer moves to set aside the Referee's Opinion and Order on the ground that it was not insured or represented by SAIF in this matter. The employer also asserts that neither it nor its counsel were notified of the hearing before the Referee. On review, the issues are jurisdiction and compensability. We affirm.

FINDINGS OF FACT

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

Claimant's request for hearing was received on June 10, 1991 and the case was set for hearing on September 4, 1991.

Copies of the notice of hearing and the Referee's Opinion and Order were mailed to all parties, including the employer.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

Motion to dismiss

Claimant contends that the Board does not have jurisdiction over this matter because the noncomplying employer has not served timely notice to SAIF. We disagree.

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

We agree with claimant's contention that SAIF was a party and should have been served with a copy of the request for Board review. However, in the absence of prejudice to an insurer, we have held that timely service of a request for review on the employer is sufficient compliance with ORS 656.295(2). Allasandra W. O'Reilly, 40 Van Natta 1180 (1988).

Assuming that claimant has standing to raise the issue of insufficient notice to SAIF, we find the rationale expressed in O'Reilly, supra, to be applicable in the present case. Here, SAIF was acting in its statutory capacity as processing agent on behalf of the noncomplying employer. ORS 656.054(1). Therefore, because the employer in this case is the party requesting review and there has been no showing that SAIF has been prejudiced in this matter, we conclude that the employer has sufficiently complied with ORS 656.295(2). Because we find that we have jurisdiction over this matter, claimant's motion to dismiss is denied.

Motion to strike

Claimant moves to strike the employer's appellant's brief on the ground that SAIF was a party to this proceeding and it was not served with a copy of the brief.

Our rules of procedure do not expressly provide that a brief not served on all other parties may be stricken. See OAR 438-11-020. However, we conclude that such a remedy is implied and is within our discretion. James M. Kleffner, 38 Van Natta 1413 (1986).

In the present case, claimant was served with a copy of the employer's brief. Furthermore, as noted above, SAIF is acting as claims processor on behalf of the noncomplying employer. Accordingly, because the employer is arguing against compensability of claimant's right knee condition, we do not find that claimant has shown that SAIF would be prejudiced by the employer's apparent failure to provide SAIF with a copy of the brief. We, therefore, conclude that the employer's appellant's brief should not be stricken.

Failure to provide notice of hearing

On review, the employer contends that it was not insured by SAIF and was not represented by SAIF. The employer argues that it has its own counsel who has appeared on the employer's behalf in prior hearings. However, the employer argues that neither it nor its attorney were notified of this hearing and there was no opportunity for the employer to appear and testify in this matter.

We first take official notice of the fact that the Referee's correspondence file in this matter contains a notice of hearing showing that, pursuant to a request for hearing received on June 10, 1991,

the case was set for hearing on September 4, 1991. Furthermore, the notice of hearing provides that copies were mailed on June 20, 1991, to the parties, including West Scio Salvage (the employer). Additionally, the Referee's order was also sent to the employer.

The employer has not argued that the Hearings Division had their address listed incorrectly. Moreover, there is no evidence that the notice of hearing was returned as undelivered. Finally, the employer was also mailed a copy of the Referee's Opinion and Order, but did not request reconsideration on the ground that it had not been mailed notice of the hearing or that it was not represented at hearing. Under the circumstances, we do not find that the employer has established that it did not receive the notice of hearing. We, therefore, conclude that the Referee properly convened the hearing with claimant and SAIF present.

Res judicata

The Referee concluded that SAIF could not deny compensability of claimant's right leg injury because: (1) claimant's initial claim expressly included the right leg; (2) there was evidence of right leg injury prior to the 1987 compensability hearing; and (3) a Board Order on Review referred to claimant's claim for the right leg and found the claim to be compensable. The Referee also noted that the Board's order was affirmed by the Court of Appeals. He, therefore, concluded that SAIF was precluded from relitigating compensability of the right leg injury.

On review, the employer argues that claimant's right leg (knee) injury was never accepted. The employer also contends that the Board's order contained a scrivener's error and it was actually compensability of the left leg, rather than the right leg, that was previously litigated.

In his respondent's brief, claimant argues that the Referee correctly ruled that SAIF could not relitigate compensability of the right leg claim, and the proper time to correct any errors in the order would have been at reconsideration. Alternatively, claimant argues that his claim is compensable on the merits.

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). 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 Co., 81 Or App 306, 309 (1986).

Here, we do not find that compensability of claimant's right leg condition has been previously litigated. Rather, we agree with the employer that the Board's order contained a scrivener's error. The Order on Review refers to claimant's testimony regarding a "puncture wound" of the right leg. However, the record and the medical evidence establish that claimant's puncture wound was to the left leg. (See Ex. 1) (emergency room report referring to claimant's left leg laceration and treatment of the injury); (Ex. 3) (Dr. Degner's report describing a "laceration to the left leg".) Furthermore, claimant's right leg condition involves a distinct right knee problem which involved pain over the medial aspect of the right knee and aching and numbness in the knee area. (Ex. 3, 3A-1).

Under the circumstances, we find that, regardless of the reference contained within the prior Board order, it was compensability of claimant's left leg injury that was litigated in the prior proceeding. Moreover, we find no evidence that compensability of the right leg or knee has been previously litigated. (For example, the denial issued by SAIF did not deny a right leg condition and the prior Referee's order refers to a "laceration to his leg which is this compensable injury.")

Accordingly, we conclude that SAIF is not barred from denying claimant's right knee condition. We, therefore, turn to the merits of compensability of the right knee condition.

Because claimant has asserted that the February 24, 1986 work-related auto accident directly caused his right knee condition, the condition will be compensable if claimant establishes that the accident was a material contributing cause of his disability or need for treatment. ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991).

Here, as noted by the Referee, Drs. Struckman and Stanford, independent medical examiners, have concluded that claimant has no objective findings and did not injure his right knee in the 1986 work-related accident. Dr. Degner, who initially treated claimant, concurred with Drs. Struckman and Stanford.

Two months after the accident, claimant was examined by Dr. Strum, M.D., upon referral from Dr. Degner. Dr. Strum took a history from claimant which noted that, following the accident, in "terms of the right knee, (claimant) had almost immediate pain and swelling of the medial aspect of the knee with somewhat diminished ability to bear weight." However, Dr. Strum did not find any bony abnormalities when he took x-rays of the right knee.

Claimant underwent arthroscopic surgery in May 1986. Dr. Strum reported that claimant was "found basically to have a negative arthroscopic evaluation." He further reported that claimant's medial jointline tenderness had resolved.

Following several years without medical treatment, claimant sought treatment from Dr. Poulson, orthopedic surgeon, for his right knee condition. Dr. Poulson reported that a March 5, 1991 MRI showed a possible tear of the anterior cruciate ligament. After reviewing claimant's prior medical records, he opined that the 1986 auto accident is the major cause of claimant's current right knee condition. He further stated that objective findings existed which established that claimant had injured his right knee. Finally, Dr. Poulson also noted that x-rays were taken of claimant's right knee following the accident, even though it was not mentioned in the emergency room report.

At hearing, the Referee found that both claimant and his witnesses had credibly testified. Claimant and the witnesses testified that he had experienced right knee pain and swelling immediately after the auto accident, even though the medical treatment at that time was primarily for his left leg laceration.

We conclude that the opinion of Dr. Poulson, claimant's treating physician, when taken in conjunction with the credible testimony of claimant and his witnesses, establish that the 1986 compensable accident was a material contributing cause of his current right knee condition. Accordingly, we agree with the Referee's conclusion that claimant's right knee condition is compensable.

Claimant is entitled to an assessed attorney fee for prevailing against the employer's request for review. 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 efforts on the issue of compensability is \$850, to be paid by the SAIF Corporation on behalf of the noncomplying employer. In reaching this conclusion, we have particularly considered the time devoted to the issue, the complexity of the issue presented, and the value of the interest involved.

ORDER

The Referee's order dated October 23, 1991 is affirmed. For services on review concerning the issue of compensability, claimant's counsel is awarded an assessed attorney fee of \$850, to be paid by the SAIF Corporation on behalf of the noncomplying employer.

In the Matter of the Compensation of
ALBERT THOMPSON, Claimant
Own Motion No. 89-0737M
OWN MOTION ORDER ON RECONSIDERATION
Popick & Merkel, Claimant Attorneys
Schwabe, et al., Defense Attorneys
Beers, et al., Defense Attorneys

The insurer has requested reconsideration of the Board's October 1, 1992 Own Motion Order Reviewing Carrier Closure in the above-captioned case. Specifically, the insurer contends that we erred in setting aside its July 13, 1992 Notice of Closure. On October 28, 1992, in order to fully consider the matter, we abated our prior order and allowed claimant an opportunity to respond. After receiving claimant's response, and further considering the matter, we make the following conclusions.

An injured worker is medically stationary when no further material improvement would be reasonably expected from medical treatment or the passage of time. ORS 656.005(17). Here, at the insurer's request, claimant was examined by Dr. Fuller of Impartial Medical Opinions, Inc., on May 6, 1992. Dr. Fuller opined that claimant had reached medically stationary status.

On June 9, 1992, Dr. Hoff, claimant's treating doctor, reviewed Dr. Fuller's report. Dr. Hoff basically agreed with Dr. Fuller's opinion. Dr. Hoff reported that the only point of disagreement was "the origin of the pain about the right knee." Moreover, Dr. Hoff opined: "In regards to the stationary status, I do not see that he is changing a great deal at this time, and I do not find that I have anything further at this point to offer him."

On July 10, 1992, Dr. Hoff reported that there was nothing that could be improved upon in claimant's knee. On July 22, 1992, Dr. Hoff reported there was nothing further that could be done to rectify claimant's "pain situation." Although, Dr. Hoff noted: "If something becomes more evident, maybe then something can be done."

Finally, on August 18, 1992, Dr. Hoff reported that claimant had injured his right knee on August 16, 1992 when his knee gave out on him. Dr. Hoff diagnosed an anterior contusion. However, this report discusses claimant's condition approximately two months after closure and speaks to an intervening incident. Accordingly, it is not relevant to claimant's medically stationary status on June 9, 1992.

Under these circumstances, we find that claimant was medically stationary as of June 15, 1992, the date of claim closure. Accordingly, we affirm the Notice of Closure in its entirety.

In his response, claimant requests penalties and attorney fees for the insurer's allegedly unreasonable failure to pay temporary disability benefits pursuant to our October 1, 1992 order. We decline to assess a penalty or attorney fee in this instance.

The Board may assess a penalty or related attorney fee if a carrier refuses to pay compensation awarded by the Board or otherwise unreasonably resists the payment of compensation. ORS 656.262(10); ORS 656.382(1). OAR 436-60-150(3)(f) provides that payment of retroactive temporary disability benefits, authorized by a litigation order, is due the date the litigation order becomes final.

Here, the Board's October 1, 1992 order set aside the insurer's July 13, Notice of Closure and remanded the matter to the insurer for processing. The effect of the Board's order was to retroactively grant claimant additional temporary disability benefits. However, on October 28, 1992, we abated our October 1, 1992 order. Inasmuch as our October 1, 1992 order did not become final, the insurer was not required to pay temporary disability benefits. Accordingly, the insurer's failure to pay temporary disability compensation was not unreasonable.

IT IS SO ORDERED.

In the Matter of the Compensation of
LUGENE JACKSON, Applicant
WCB Case No. CV-92003
FINDINGS OF FACT, CONCLUSIONS AND PROPOSED ORDER (CRIME VICTIM ACT)
Stoll & Stoll, Attorneys
Michael O. Whitty, Assistant Attorney General

Pursuant to notice, a hearing was conducted and concluded by Keith Kekauoha, special hearings officer, on September 18, 1992 at Portland, Oregon. Applicant, Lugene Jackson, was present and represented by his attorney, Steve D. Larson. The Department of Justice Crime Victims' Compensation Program ("Department") was represented by Michael O. Whitty, Assistant Attorney General. The court reporter was Jan Nelsen. The record was closed September 18, 1992.

Applicant requested review by the Workers' Compensation Board of the Department's Findings of Fact, Conclusions and Order on Reconsideration dated January 23, 1992. 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 failure to establish the eligibility criteria under ORS 147.015(1) through (6).

FINDINGS OF FACT

On October 23, 1990, applicant filed a claim for compensation with the Department, alleging that he had been the victim of an assault on the night of September 7, 1990. Specifically, applicant stated that he was walking along a street when three individuals got out of a car and beat and robbed him. He was taken by ambulance to Good Samaritan Hospital, where he was hospitalized for 10 days. According to hospital records, applicant sustained a blunt trauma to the face and a right trimalleolar ankle fracture. His blood alcohol level at the time of admission was .404 percent, but he was conscious and alert.

On September 9, 1990, applicant underwent an open reduction and internal fixation of the ankle fracture. The next day, applicant had a fever and was experiencing some agitation and visual hallucinations, which were suspected to be due to acute alcohol withdrawal. On September 11, 1990, applicant's condition improved, and he began physical therapy for his ankle. The physical therapy continued until his discharge from the hospital on September 17, 1990.

On October 22, 1990, approximately five weeks after his discharge from the hospital, applicant filled out the application form for crime victim compensation. On the form, applicant wrote that he reported the alleged assault to a law enforcement agency on September 7, 1990, adding: "I think it was reported I was transported to hospital."

However, police records show that applicant reported the incident on October 22, 1990. There is no record of a prior report of the incident to any law enforcement agency. According to the police report, applicant was walking along a street when a man jumped out of a car and demanded his belongings. Applicant stated that he was hit, first from behind by another man, and later by the car driven by a woman. Applicant stated that the police were called to the scene, and he was taken by ambulance to the hospital. There were no witnesses to the incident.

On December 9, 1991, the Department issued its Findings of Fact, Conclusions and Order denying applicant's claim for compensation. Noting applicant's level of intoxication at the time of the incident and the 45-day delay in reporting the incident to the police, the Department found insufficient evidence to establish that: (1) law enforcement officials were notified within 72 hours of the incident, or there was good cause for untimely notification; (2) applicant had cooperated fully with law enforcement officials in the apprehension and prosecution of the assailant(s), or there was good cause for lack of cooperation; and (3) applicant's injury was not substantially attributable to his wrongful act or substantial provocation of the assailant(s).

Applicant requested reconsideration through his attorney, asserting that he immediately reported the incident to police just before he was taken by ambulance to the hospital and that he is not responsible for any delay in filing a report of the incident. On reconsideration, the Department found:

(1) there was no timely police report or investigation of the incident; (2) applicant gave conflicting statements as to whether a police report was ever filed within 72 hours of the incident; (3) the incident was unwitnessed; and (4) applicant's blood alcohol level was highly elevated shortly after the incident. Based on those findings, the Department concluded there was insufficient evidence that applicant met the eligibility criteria listed in ORS 147.015(1) through (6). Applicant requested Board review of the Department's order.

CONCLUSIONS OF LAW AND OPINION

The standard of review for cases 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(2), applicant is entitled to compensation under the Act if law enforcement officials were notified of the perpetration of the crime allegedly causing his injury within 72 hours after its perpetration, unless there is good cause for lack of timely notification. "Good cause for failure to notify the appropriate law enforcement officials within 72 hours after the perpetration of the crime" means physical or mental trauma causing an inability to report the crime as required. OAR 137-76-010(5).

Applicant has stated, with varying degrees of certainty, that he reported the alleged assault to the police on the day of the incident. The record shows, however, that no such police report could be located. Because applicant was highly intoxicated and had sustained a blow to the head in the incident, I find his recollection concerning his reporting of the incident not to be reliable. Rather, I am most persuaded by the lack of an original police report concerning the incident. Accordingly, I find that applicant did not report the incident to law enforcement officials within 72 hours of the incident.

I next turn to the question of whether applicant has established good cause for his failure to timely notify the police. Applicant had sustained trauma to his face and his leg in the incident on September 7, 1990, and was hospitalized for 10 days. Although applicant was described as conscious and alert at the time of admission to the hospital, he underwent ankle surgery on September 9, 1990, and, while recovering from surgery, developed a fever and experienced agitation and visual hallucinations during the next day. Under these circumstances, I find that applicant sustained a physical and mental trauma which rendered him unable to report the assault within 72 hours of the incident. Thus, I conclude that applicant had good cause for failing to report within 72 hours of the incident.

However, I do not find that applicant was entirely relieved of the obligation to report the alleged assault to law enforcement officials within a reasonable period of time following the incident. An applicant is required to cooperate fully with law enforcement officials in the apprehension and prosecution of the assailant(s), unless there is good cause for the failure to cooperate. ORS 147.015(3). "Good cause for failure to cooperate" exists when the victim receives express or implied threats that cooperation will result in death or serious physical injury to the victim or another person. OAR 137-76-010(4).

Here, I do not find that applicant cooperated fully with law enforcement officials. Full cooperation with law enforcement officials includes promptly reporting the crime to officials. Applicant did not report the alleged assault until 45 days after the incident, or 35 days after his discharge from the hospital. There is no evidence that applicant received any threat that cooperation would result in harm to himself or another.

Applicant explains that, because he believed the police was present either at the scene of the incident or the hospital, he assumed the incident had been timely reported to the police. When he later applied for crime victim compensation and learned there was no police report on the incident, he promptly reported it to the police.

Applicant's explanation does not establish good cause. At the time of the incident, applicant had sustained a blow to the head and was highly intoxicated. Under those circumstances, the reliability of his recollection as to who was present at the scene or the hospital is questionable. In fact, when he filled out the claim form for crime victim compensation, he was not sure that he had reported the alleged assault, stating: "I think it was reported." Given his uncertainty as to whether the incident had been reported, applicant should have taken reasonable steps to make certain that the report was made.

Instead, he waited more than a month before finally reporting the incident. Accordingly, I do not find that applicant had good cause for his failure to cooperate fully with law enforcement officials.

Finally, even had applicant established good cause for failure to cooperate, I am not persuaded that he was the victim of a compensable crime, as required by ORS 147.015(1). "Compensable crime" means an intentional, knowing or reckless act that results in serious bodily injury or death of another person and which, if committed by a person of full legal capacity, would be punishable as a crime in this state. ORS 147.005(4).

The alleged assault was unwitnessed; therefore, I must rely on applicant's account of the incident. However, the reliability of applicant's account is severely undercut by the facts that he was highly intoxicated at the time of the incident and he waited more than a month before reporting the incident to the police. Additionally, applicant's physical injuries alone do not establish that he was the victim of an intentional, knowing or reckless act. Inasmuch as applicant's claim does not satisfy all of the statutory requirements for receiving benefits under the Act, his claim for benefits must be denied.

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 compensation. For the reasons detailed above, these requirements have not been satisfied. Accordingly, his claim for compensation 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 January 23, 1992 be affirmed.

November 18, 1992

Cite as 44 Van Natta 2320 (1992)

In the Matter of the Compensation of
LUGENE JACKSON, Applicant
 WCB Case No. CV-92003
ORDER ON RECONSIDERATION (CRIME VICTIM ACT)
 Stoll & Stoll, Attorneys
 Michael O. Whitty, Assistant Attorney General

Applicant, *pro se*, requests reconsideration of Special Hearings Officer Keith Kekauoha's October 20, 1992 Findings of Fact, Conclusions and Proposed Order which affirmed the Findings of Fact, Conclusions and Order on Reconsideration of the Department of Justice Crime Victims Compensation Fund. In his October 20, 1992 proposed order, the Special Hearings Officer affirmed the Department's decision to deny applicant's claim for compensation because: (1) applicant did not fully cooperate with law enforcement officials in the apprehension and prosecution of the assailants, and did not show good cause for his failure to do so; and (2) applicant did not prove that he was the victim of a compensable crime.

Applicant makes a number of points in his motion. First, he notes his military service as a World War II veteran and his persistent health problems dating back to 1968. He explains that he had not heard of the Crime Victims Compensation Program until he was contacted by someone from the county courthouse after his release from the hospital. He contends that his doctor can verify that he was beaten and robbed. Finally, he states his belief that he was assaulted because of his previous cooperation with the police in identifying drug houses. We have considered applicant's motion and conducted our review of the record.

We acknowledge the difficulties suffered by applicant as a result of this tragic incident. However, we are bound to apply the Crime Victims Compensation Act as enacted by the legislature. The legislature has mandated that an applicant satisfy specific requirements before receiving compensation under the Act. One of those requirements is that an applicant must cooperate fully with law enforcement officials in the apprehension and prosecution of the assailant(s), unless there is good cause for the failure to cooperate. ORS 147.015(3).

Thus, even if applicant was the victim of a crime, he must still meet the requirement of full cooperation with law enforcement officials. By waiting more than a month after his discharge from the hospital to report the assault, applicant impaired the ability of law enforcement officials to investigate the assault and to apprehend the assailants. Applicant's statement that he did not know about the Crime Victims Compensation Fund does not present sufficient grounds to excuse his delay in reporting the assault. Therefore, in the absence of good cause for the delay, applicant does not qualify for compensation under the Act.

After completing our review, we adhere to and republish the October 20, 1992 Findings of Fact, Conclusions and Proposed Order, as supplemented herein.

IT IS SO ORDERED.

November 19, 1992

Cite as 44 Van Natta 2321 (1992)

In the Matter of the Compensation of
ALENE M. ALLEN, Claimant
WCB Case No. 91-09479
ORDER ON REVIEW
Westmoreland, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

The self-insured employer requests review of Referee Bethlahmy's order that: (1) directed it to process claimant's cervical claim to closure; and (2) assessed a penalty for its unreasonable refusal to process the claim to closure. On review, the issue is claim processing and penalties.

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

The employer argues that the parties' August 20, 1990 Stipulated Settlement relieved it of the obligation to close claimant's claim for a cervical condition. Specifically, the employer argues that, by operation of the "claim preclusion" rule of res judicata, the stipulation barred claimant from enforcing the employer's obligation to close the cervical claim. We disagree.

The doctrine of res judicata precludes relitigation of claims and issues previously adjudicated. North Clackamas School Dist. v. White, 305 Or 48, 50, on recon 305 Or 468 (1988). The preclusive effect on a claim is called "claim preclusion." See id. 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).

At the time of the parties' stipulation, claimant had claims for two separate conditions: bilateral carpal tunnel syndrome (CTS) and a cervical spine condition. The CTS claim was accepted by the employer; it was initially closed by Determination Order on April 11, 1989, with a permanent disability award. The claim was later reopened for an aggravation, and again closed by October 6, 1989 Determination Order with an additional award of permanent disability benefits. At the time of the August 20, 1990 stipulation, claimant had a pending request for hearing on the October 6, 1989 Determination Order, seeking an additional award of permanent disability benefits.

The cervical claim, on the other hand, was denied by the employer on May 17, 1989. That denial was subsequently set aside by Referee Harri's order dated February 1, 1990, as reconsidered on March 27, 1990. Referee Harri's order remanded the claim to the employer for acceptance, processing, and the payment of compensation according to law. The employer requested Board review of that order on April 3, 1990. That request was pending at the time of the stipulation.

The stipulation recites some history of the CTS claim, including the fact that claimant had requested a hearing on the October 6, 1989, seeking an additional permanent disability award. The stipulation then states, in relevant part:

"The parties wish to resolve this matter by settlement;

"IT IS HEREBY STIPULATED AND AGREED that this matter be compromised and settled * * * by [the employer] paying and claimant accepting, an additional 14% scheduled disability, making a total award of 58% scheduled disability. * * * * In consideration for this payment, claimant agrees that this resolves all issues that were raised or that were raisable and her Request for Hearing shall be dismissed with prejudice." (Ex. 66A)

Subsequent to the stipulation, on March 13, 1991, the Board affirmed Referee Harri's order finding the cervical claim compensable.

Based on the language of the stipulation, as well as the circumstances surrounding it, we are not persuaded that the parties litigated to final judgment any matter concerning the cervical claim. Rather, it is apparent that the stipulation was directed solely to issues relating to the accepted CTS condition. The stipulation dismissed the hearing request in WCB Case No. 90-04609, which related to the CTS claim, and did not purport to affect any matter relating to the cervical claim in WCB Case No. 89-10499. Accordingly, the stipulation was not a final judgment as to the issue of the closure of the cervical claim. See, e.g., Dave E. Herman, 42 Van Natta 2104 (1990).

Moreover, at the time of the stipulation, the employer had a pending appeal concerning the compensability of the cervical condition, and contrary to the employer's contention on review, there was no medical opinion declaring claimant's cervical condition to be medically stationary. Inasmuch as claimant's cervical claim could not be closed until claimant's condition became medically stationary, see ORS 656.268, the closure issue was not "raisable" at the time of the stipulation.

Finally, we do not find that the closure issue is a "claim" for purposes of "claim preclusion." A "claim," or cause of action, is an aggregate of operative facts which compose a single occasion for judicial (or administrative) relief. Carr v. Allied Plating Co., supra, 81 Or App at 310. Thus, a claim encompasses a remedial right to relief, e.g., temporary and permanent disability benefits. The closure of a claim, on the other hand, is a statutory duty of the employer in processing a claim for compensation. Therefore, we do not agree with the employer that res judicata applies to bar claimant from what is essentially an employer's claim processing duty.

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 claim processing 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. We further note that claimant is not entitled to an attorney fee for services on Board review concerning the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The Referee's order dated February 5, 1992 is affirmed. Claimant's attorney is awarded \$1,000 for services on Board review, to be paid by the self-insured employer.

In the Matter of the Compensation of
KRISTINE M. CARTMELL, Claimant
WCB Case No. 91-03493
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Kinsley, Brazeau and Hooton.

Claimant requests review of those portions of Referee Schultz's order which: (1) reduced her unscheduled permanent disability award from 9 percent (28.8 degrees), as awarded by Determination Order, to 7 percent (22.4 degrees); and (2) granted the self-insured employer's request to offset its overpayment of unscheduled permanent disability against any future permanent disability awards. On review, the issues are extent of unscheduled permanent disability and offset.

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

On reconsideration, the Referee granted the employer's request to offset the overpayment resulting from the reduced unscheduled permanent disability award against any future permanent disability awards. On review, claimant contends that there is no statutory entitlement to such an offset. We disagree.

In V.W. Johnson & Sons v. Johnson, 103 Or App 355 (1990), the court held that former ORS 656.268(10) (now ORS 656.268(13)) creates a right to an offset. There, the Board awarded claimant permanent total disability (PTD) benefits retroactively, but denied the self-insured employer's request for an offset for permanent partial disability benefits it had already paid on the claim. The Board denied the employer's request for an offset on the basis that the employer had waived the offset request by not making the request at hearing before the Referee. The court reversed, holding that former ORS 656.268(10) permitted the offset and that the employer did not waive its right to the offset. Id. at 358.

Thus, the court has liberally construed the language in ORS 656.268(13) to permit a Referee and the Board to make necessary adjustments in compensation. That construction is consistent with the objective of providing fair administration of benefits for workers. Therefore, we conclude that the Referee's offset authorization is permitted by ORS 656.268(13).

Furthermore, OAR 436-60-170(1) provides:

"Insurers may recover overpayment of benefits paid to a worker only as specified by ORS 656.268(13), unless authority is granted by a referee or the Workers' Compensation Board." (Emphasis added.)

Pursuant to that rule, the Referee had authority to allow the offset. Moreover, because the employer requested the offset on reconsideration of the Referee's order, we reject claimant's argument that the employer waived its right to the offset.

Finally, we do not agree with the dissent's view that ORS 656.313(2) prohibits authorization of the offset in this case. 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 the review or appeal." (Emphasis added.)

According to its plain meaning, the statute applies only to compensation that is paid pending Board review or court appeal; it does not apply to compensation paid pending a hearing before a Referee. This interpretation is supported by the fact that ORS 656.313(1)(a) expressly distinguishes a request for hearing from a request for board review or court appeal. Here, the amount the employer seeks to offset were paid pending hearing. Accordingly, we conclude that ORS 656.313(2) does not preclude the authorization of an offset in this case.

Claimant also requests that she be awarded a reasonable assessed attorney fee if she prevails on either the extent of permanent disability issue or the offset issue. Because claimant did not prevail on either issue on review, she is not entitled to an assessed attorney fee. See ORS 656.386(1).

ORDER

The Referee's order dated September 3, 1991, as reconsidered September 19, 1991, is affirmed.

Board Member Hooton dissenting.

The majority concludes that because the court has previously held that an offset may be allowed even though the issue was not raised at the time of hearing, there is a basis for allowing the offset in the present claim. That is not the issue. Claimant correctly contends that there is no statutory authority for the offset awarded in this instance.

ORS 656.313(2) expressly provides that, should the Board order that compensation paid to claimant pending 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 v. Louisiana-Pacific, 67 Or App 577, 581, rev den 297 Or 340 (1984); Debbie L. Stadtfeld, 44 Van Natta 1474 (1992); Hector Delhorno, 43 Van Natta 1221 (1991). ORS 656.268(13), relied on by the majority, applies, by its terms, only to "necessary adjustments in compensation paid or payable prior to the determination or notice of closure," (emphasis added), and therefore cannot be the basis of an offset based on a reduction of permanent partial disability compensation made payable by a determination or notice of closure.

In this claim the Board has reduced the compensation made payable by a determination or notice of closure, and has allowed an offset against future permanent partial disability compensation for permanent disability compensation paid pending review of the Determination Order without regard for the prohibition in ORS 656.313(2). The mere fact that the review of the Determination Order was first completed and the offset first authorized in the Hearings Division is of no consequence. The authority of the Hearings Division to grant an offset in any instance is derivative of the Board's authority to award such relief. The Board does not have that authority. Neither does the Hearings Division.

Because I would find that ORS 656.313(2) prohibits the allowance of an offset in this instance, I would reverse that portion of the Referee's order allowing offset of the overpaid permanent disability benefits against future permanent disability benefits.

November 19, 1992

Cite as 44 Van Natta 2324 (1992)

In the Matter of the Compensation of
MARK E. DOMES, Claimant
WCB Case No. 91-07326
ORDER ON REVIEW
Flaxel, Todd, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Hooton and Brazeau.

Claimant requests review of that portion of Referee Howell's order that upheld the SAIF Corporation's denial of claimant's left forearm/wrist claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the following supplementation. Claimant's left arm is his dominant arm.

FINDINGS OF ULTIMATE FACT

Claimant's disability and need for treatment for his left forearm/wrist arose out of and in the course of his employment.

Claimant's left forearm/wrist injury is established by medical evidence supported by objective findings.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant failed to carry his burden of proving that he sustained a compensable occupational disease. Claimant contends that his claim is properly analyzed as a claim for accidental injury, rather than an occupational disease, and that he has met his burden of proof. We agree.

An occupational disease is characterized by a gradual onset of symptoms and is generally not unexpected, given the nature of claimant's continuing work exposure. James v. SAIF, 290 Or 343 (1981). An accidental injury, on the other hand, is generally the unexpected consequence of either an identifiable incident, or an onset traceable to a discrete time period. Valtinson v. SAIF, 56 Or App 184 (1982).

Here, claimant had worked for the employer as a roofer, tearing off old roofs and installing new ones, for a month. Based on claimant's testimony regarding the onset of pain at the end of the workday on April 29, 1991, and his return to work the next morning which was quickly curtailed by increased pain, as well as the consistent histories he related to the emergency room and treating physicians, we conclude that the onset of claimant's left forearm condition is traceable to a discrete time period, i.e., on or about April 29, 1991. For these reasons, we conclude that claimant's claim is properly analyzed as an injury. See Donald Drake Co. v. Lundmark, 63 Or App 261, 266 (1983), rev den 296 Or 350 (1984); Valtinson, supra.

In order to carry his burden of proving a compensable injury, claimant must establish that he experienced an injury arising out of and in the course of his employment on or about April 29, 1991. Claimant must prove that the injury was a material contributing cause of his subsequent disability and need for treatment for his left forearm/wrist. See ORS 656.005(7)(a); Mark N. Weidle, 43 Van Natta 855 (1991). In addition, ORS 656.005(7)(a) requires that claimant's disability or need for medical services be established by medical evidence supported by objective findings. See Suzanne Robertson, 43 Van Natta 1505 (1991).

Here, claimant's left forearm/wrist condition arose after he had worked most of the day ripping off a roof by means of a heavy instrument. Claimant is left-hand dominant. Although claimant admitted that he lifted weights, he testified that he did not do so the weekend prior to the injury and that he had not experienced any forearm/wrist tendonitis as a result of his weightlifting. He also testified that he may have mentioned to another witness that a combination of work activities and weightlifting had made his arms sore. That witness testified that claimant told him that he had had problems from weightlifting. However, the witness's testimony was unclear as to when claimant had divulged that information and unclear as to whether claimant was referring to his general arm soreness or the specific incident that is the subject of this claim. Thus, there is no persuasive evidence that counters claimant's testimony.

In any event, claimant conceded that he had experienced some soreness as a result of work and weightlifting. Based on this concession, the Referee found the opinion of Dr. Whitney, claimant's treating doctor, to be unpersuasive as to the cause of claimant's condition, in that he was unaware of claimant's weightlifting activities. (O & O p. 3). We do not find Dr. Whitney's opinion unpersuasive on these grounds. First, there is no indication that Dr. Whitney was not aware of claimant's weightlifting activities. Second, claimant had not lifted weights for several days prior to April 29, 1991. Third, claimant had been performing potentially causal work activities for almost a full work day prior to the onset of pain and swelling. Finally, we do not find the question of material contribution by claimant's work activities to be of such medical complexity as to require the medical opinion to establish more than the causal connection established by Dr. Whitney's reports. We accordingly find Dr. Whitney's opinion, which is uncontradicted by other medical evidence, to be persuasive.

Furthermore, when claimant sought treatment, Dr. Harding, the emergency room physician, noted crepitation over the radial forearm with radial deviation. He treated these conditions with a splint and medication. Dr. Whitney noted the same symptoms and continued conservative treatment. The contents of the doctors' medical reports constitute medical evidence supported by objective findings that claimant experienced a left forearm/wrist condition that required treatment. See ORS 656.005(19); Robertson, supra. Consequently, we conclude that claimant has proven that he experienced a left forearm/wrist injury on or about April 29, 1991, that the injury arose out of and in the course of his employment, and that the injury is a material contributing cause of his need for medical treatment for his left forearm/wrist. His claim is compensable.

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 \$3,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and appellant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated September 27, 1991 is reversed in part and affirmed in part. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. The remainder of the order is affirmed. Claimant's attorney is awarded \$3,000 for services at hearing and on Board review, to be paid by the SAIF Corporation.

November 19, 1992

Cite as 44 Van Natta 2326 (1992)

In the Matter of the Compensation of
SILVERIO FRIAS-PEREZ, Claimant
WCB Case No. 92-00616
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Neidig and Moller.

Claimant requests review of that portion of Referee T. Lavere Johnson's order that found that his claim was not prematurely closed by an April 5, 1991 Determination Order. On review, the issue is premature closure. 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 incorrectly relied upon a December 6, 1990 closing report by Dr. Pollard, as there is no report in the record which bears that date. Claimant argues that the remaining reports are not sufficient to establish that he is medically stationary.

Although the Referee correctly noted other references in the record to such a report, we agree with claimant that there is no December 6, 1990 report in the record. However, we do not agree with claimant's argument that the burden of proof in this case initially rests with the insurer. Moreover, we agree with the remainder of the Referee's order which found that claimant failed to establish that he was not medically stationary at the time of the April 5, 1991 Determination Order. We, therefore, affirm the Referee on the issue of premature closure.

ORDER

The Referee's order dated March 31, 1992 is affirmed.

November 19, 1992

Cite as 44 Van Natta 2327 (1992)

In the Matter of the Compensation of
ROGELIO R. ROJAS, Claimant
WCB Case Nos. 90-14437 & 90-09933
ORDER ON REVIEW
Max Rae, Claimant Attorney
Meyers & Radler, Defense Attorneys
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Hooton and Brazeau.

Claimant requests review of Referee Baker's order which: (1) upheld the SAIF Corporation's denial of an aggravation claim for a low back injury; and (2) upheld the self-insured employer's denial of a "new injury" claim for the same condition. On review, the issues are responsibility and aggravation. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINIONResponsibility

Under ORS 656.308(1), in cases in which an accepted injury is followed by an increase in disability during employment with a later carrier, responsibility presumptively rests with the original carrier unless the claimant sustains an actual, independent, compensable injury or occupational disease during the subsequent work exposure. Ricardo Vasquez, 43 Van Natta 1678, 1680 (1991); Donald C. Moon, 43 Van Natta 2595 (1991). Therefore, as the original carrier, SAIF presumptively remains responsible absent proof that claimant sustained a new, compensable injury during his work with the subsequent self-insured employer. Alternatively, to shift responsibility on an occupational disease basis, SAIF must prove that work activities for the subsequent employer were the major contributing cause of a pathological worsening of claimant's accepted low back strain. ORS 656.802(2); Donald C. Moon, *supra*.

Here, claimant does not allege that a discrete injury occurred during his employment with United Foods, the subsequent employer. (Tr. 24-25). Nor does SAIF contend that claimant sustained a new injury while working for United Foods. (See Ex. 52).

After our review of the record, we find that the evidence also fails to establish that claimant's work activities at United Foods were the major contributing cause of a pathological worsening of his compensable low back strain. Only two independent medical examiners addressed this question directly: neurologist Dr. Wilson and chiropractor Dr. Abrams. Both concluded that claimant's work activities at United Foods did not worsen his underlying condition. (Exs. 71, 74). Dr. Nickila, claimant's initial treating chiropractor, could not say whether claimant's underlying condition worsened, nor could he say that work activities at United Foods were the major contributing cause of claimant's disability and need for treatment after October 13, 1989. (Ex. 76-2 to 76-3).

Therefore, we conclude that claimant sustained neither a new injury nor a new occupational disease while working for the subsequent employer. Accordingly, we affirm the Referee's conclusion that SAIF remains responsible for claimant's accepted low back condition.

Aggravation

The Referee found that claimant had proved no more than waxing and waning of symptoms, and therefore, upheld SAIF's aggravation denial. We disagree and find that claimant has proved an aggravation of his compensable low back condition.

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).

Here, the medical evidence uniformly establishes that claimant experienced an increase in symptoms of his compensable low back condition in October 1989. Independent examiners Wilson and Abrams both opined that claimant's work at United Foods increased his symptoms, but did not worsen his underlying condition. (Exs. 71, 74). Dr. Wheeler, claimant's treating chiropractor after Dr. Nickila, opined that claimant's work at United Foods "merely inhibited the opportunity of proper healing and increased symptoms." (Ex. 70).

Dr. Nickila, who treated claimant at the time of the alleged worsening, reported several positive, objective findings of an exacerbation and authorized temporary disability beginning October 13, 1989. (Exs. 37, 37A, 39; see also Ex. 76-2). Dr. Nickila reported muscle spasms in the lumbosacral joint (Ex. 68-1), and explained that the positive orthopedic findings on October 13, 1989 indicated a worsening and swelling of the lumbosacral disc area, as compared with claimant's condition immediately prior to that date. (Ex. 76-2). Prior to October 13, 1989, claimant had been receiving weekly chiropractic treatment to enable him to continue working, and he had been working successfully up to 10 hours per day. (Exs. 36, 68-1).

Accordingly, we find that claimant experienced a worsening of his compensable low back condition on and after October 13, 1989, which manifested in increased symptoms and resulted in diminished earning capacity.

We further conclude that claimant has established more than a waxing and waning of his symptoms, as contemplated by the last award or arrangement of compensation.

ORS 656.273(8) provides that "the worker must establish that the worsening is more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award." The fact that claimant received a permanent disability award does not create a presumption that future periods of waxing and waning of symptoms were contemplated in the award. Instead, the record must establish that future periods of waxing and waning of symptoms were, in fact, contemplated at the time of the last arrangement of compensation. Lucas v. Clark, 106 Or App 687 (1991); Patricia V. Standard, 44 Van Natta 911 (1992).

Claimant's last arrangement of compensation is a May 27, 1988 stipulation, which awarded him 10 percent (32 degrees) unscheduled permanent disability for his low back strain. Nothing in the stipulation indicates that the parties at that time contemplated future periods of waxing and waning of symptoms, nor that the parties intended for the stipulated permanent disability award to encompass anticipated periods of waxing and waning of symptoms. (See Ex. 32). The April 6, 1988 Determination Order awarded no permanent disability. (Ex. 29A). The closing examination on March 15, 1988 found claimant to be medically stationary with no measurable impairment and able to return to regular work. The medical examiners also found no evidence of the need for further treatment. (Ex. 28-3). In May 1988, claimant's treating physician returned him to regular duty with no restrictions. (Ex. 30). Under these circumstances, we conclude that future periods of waxing and waning of symptoms were not contemplated at the time of claimant's last arrangement of compensation.

Accordingly, we conclude that claimant has established a compensable aggravation. See Lewis L. Seals, 44 Van Natta 898 (1992).

Attorney Fees

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the aggravation issue is \$3,500, to be paid by the SAIF Corporation. ORS 656.386(1). In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by appellant's brief and the hearing record), the complexity of the issue, and the value of interest involved.

ORDER

The Referee's order dated October 22, 1991 is affirmed in part and reversed in part. The SAIF Corporation's aggravation denial is set aside and the claim is remanded to SAIF for processing according to law. The remainder of the Referee's order is affirmed. For services at hearing and on review concerning the aggravation issue, claimant's attorney is awarded an assessed fee of \$3,500, payable by SAIF.

November 19, 1992

Cite as 44 Van Natta 2329 (1992)

In the Matter of the Compensation of
RONALD E. SMITH, Claimant
WCB Case No. 91-15556
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Neidig and Moller.

The insurer requests review of that portion of Referee Crumme's order that found that a Determination Order had prematurely closed claimant's claim for his low back condition. On review, the issue is premature closure. We reverse.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of "Finding" number 12.

CONCLUSIONS OF LAW AND OPINION

The Referee found that, on January 21, 1991, and through the date of hearing, further material improvement in claimant's condition was reasonably likely to occur. We disagree.

Under ORS 656.268(1), claims shall not be closed if the worker's condition has not become medically stationary. "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). It is claimant's burden to show that he was not medically stationary on the date of closure. Berliner v. Weyerhaeuser, 54 Or App 624 (1981). In determining whether claimant has carried this burden, we examine medical evidence available at the time of closure, as well as evidence submitted after closure; however, medical evidence submitted after closure that pertains to changes in claimant's condition subsequent to closure is not considered. Scheuning v. J.R. Simplot & Company, 84 Or App 622, rev den 303 Or 590 (1987).

Here, the parties argue that claimant's status should be assessed as of January 21, 1991, the medically stationary date provided by the June 13, 1991 Determination Order. However, the proper inquiry for determining whether the claim was permanently closed is whether claimant was medically stationary on June 13, 1991, which was the date of closure.

On June 11, 1991, Dr. Burton, claimant's treating physician, reported that, in reviewing his chart notes and considering the medical course of claimant since he first started treating him in September 1990, he presently considered claimant "medically stationary and stable."

On June 25, 1991, Dr. Burton's chartnotes indicated that claimant would be scheduled for a consultation with Dr. Lahey "with the idea of re-exploration of the L4-5 area and possible lumbar fusion."

On July 9, 1991, Dr. Burton reported that claimant had a condition which might "likely eventuate in further surgical treatment." Dr. Burton opined that, considering the possibility of further surgery, claimant was not medically stationary.

On July 9, 1991, Dr. Lahey examined claimant and reported that Dr. Burton had "done all he can" and was referring claimant to him for another opinion, "possibly surgical." Dr. Lahey scheduled claimant for a CT/myelogram.

On October 9, 1991, in response to a letter from claimant's attorney, Dr. Burton stated that, although he had said claimant was medically stationary in January 1991, in actuality, he was still waiting to see whether or not he would recommend surgery, and if he recommended surgery, then claimant would not be stable. Dr. Burton stated that he was probably wrong in estimating that claimant was medically stationary in January 1991, and he believed claimant "remained medically unstable up until this time." He concluded that, if claimant refused surgery for any reason, "at that time we can again consider him medically unstationary [sic]."

We do not find that Dr. Burton's opinion clarifies the issue of whether claimant was medically stationary on June 13, 1991. Dr. Burton had twice previously found that claimant was stable and medically stationary. Furthermore, his opinion after claim closure states that if he recommended surgery, then claimant would not be stable. However, at the time of claim closure, Dr. Burton had not recommended surgery. Moreover, it was not until after the time of closure that Dr. Burton referred claimant to Dr. Lahey for a possible opinion regarding surgery. Dr. Lahey subsequently reported that claimant was "not felt to be a surgical candidate."

Accordingly, we conclude that claimant has failed to establish that further material improvement in his condition could reasonably be expected as of the date of closure. We, therefore, reverse the Referee on the issue of premature closure. Inasmuch as premature closure was the sole issue raised at hearing, we reinstate and affirm the June 13, 1991 Determination Order and August 15, 1992 Order on Reconsideration.

ORDER

The Referee's order dated March 30, 1992 is reversed in part. That portion of the Referee's order that set aside the June 13, 1991 Determination Order and August 15, 1991 Order on Reconsideration is reversed. The Orders are reinstated. The Referee's out-of-compensation attorney fee resulting from the premature closure finding is reversed. The remainder of the Referee's order is affirmed.

November 20, 1992

Cite as 44 Van Natta 2330 (1992)

In the Matter of the Compensation of
LONNY R. LEE, Claimant
WCB Case No. 92-01044
ORDER ON REVIEW
Black, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of Referee Mongrain's order that awarded 20 percent (64 degrees) unscheduled permanent disability for claimant's low back condition, whereas an Order on Reconsideration had awarded 15 percent (48 degrees). On review, the issue is extent of unscheduled permanent disability.

We affirm and adopt the order of the Referee, except that the second sentence in the second paragraph of the "Opinion" section is replaced as follows.

The medical opinions describing claimant's L4 vertebral fracture as injury-related are uncontradicted. Dr. Dickerson, independent examiner, refers to the L4 fracture as an "avulsion fracture" and a "compression fracture." (See Ex. 5A-8). Based on Dickerson's opinion establishing that claimant has a fractured single vertebral body at L4, claimant has proven entitlement to a rating for that fracture under OAR 436-35-350(1).

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 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.

ORDER

The Referee's order dated April 7, 1992 is affirmed. For his services on review, claimant's counsel is awarded an assessed fee of \$500, payable by the insurer.

November 20, 1992

Cite as 44 Van Natta 2331 (1992)

In the Matter of the Compensation of
JOANNE LUTTON, Claimant
WCB Case Nos. 91-04295 & 91-10955
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
John Motley (Saif), Defense Attorney

Reviewed by Board Members Westerland and Gunn.

Claimant requests review of those portions of Referee Michael V. Johnson's order that: (1) upheld the SAIF Corporation's denial of her claim for a headache condition; and (2) upheld the SAIF Corporation's denial of her claim for a 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

Headache Condition

The Referee concluded that claimant's accepted condition was not the major contributing cause of her preexisting headache condition. Therefore, the Referee found that claimant had failed to establish compensability of the headache condition. We agree.

ORS 656.005(7)(a)(B) applies where a compensable injury combines with a preexisting disease or condition to cause or prolong disability or need for treatment. Under the statute, 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. We have construed the statute as requiring a two-step determination. Bahman N. Nazari, 43 Van Natta 2368 (1991). First, claimant must prove that the industrial accident is a material contributing cause of disability or need for treatment. Next, in determining the compensability of the resultant condition, claimant must prove the compensable injury, rather than the preexisting condition, is the major contributing cause of her disability or need for treatment. Id.

Here, the medical record establishes that claimant has suffered from her headache condition since 1984, prior to the occurrence of the 1988 and 1989 compensable injuries. Three physicians address

the causation of claimant's headache condition. Dr. Matthews concluded that claimant's muscle contraction headaches preexisted her injury and were exacerbated by her chronic pain syndrome. Matthews did not feel, however, that claimant's work injury was the primary cause of her headaches.

Dr. Steinhauer also opined that claimant's findings on examination were most consistent with a diagnosis of muscle contraction headaches. Steinhauer stated that the headache condition was not primarily related to claimant's compensable low back condition and that, at most, the headaches could be a secondary problem associated with stress and chronic pain.

Finally, Dr. Lewis, claimant's attending physician, opined only that he did not feel that the 1988 injury was the cause of claimant's migraine headaches or that the September 30, 1990 emergency room treatment for headaches was related to claimant's 1989 compensable injury. Based on this evidence, we find that claimant's preexisting headache condition, as opposed to either of her compensable injuries, was the major contributing cause of her disability and need for treatment. Consequently, we agree with the Referee that claimant has not established the compensability of her headache condition.

Off-Work Fall Injury

The Referee found that claimant's off-work fall on some hospital steps, while visiting a friend, and the hospitalization and medical treatment necessitated by the fall, were not compensably related to her accepted low back condition. We agree.

Claimant explained to an emergency room physician that she did not see several steps and tripped on them sustaining her injuries. Thus, claimant does not contend that her fall is a consequence of the compensable back condition. Rather, she argues that without the compensable injury, her back would not have hurt so badly nor would she have required hospitalization.

Regarding the July 23, 1990 fall, Dr. Lewis, the attending physician stated:

"In my medical opinion more likely than not, [claimant's] 1989 industrial injury is still the major contributing cause to her need for medical attention relative to her back. Her fall on the steps of Kaiser Hospital on July 23rd, 1990 was an aggravation of her back condition. Her hospitalization at that time however, I would state was directly related to this fall as even though there was no material worsening of her underlying condition she certainly would not have required medical attention at that time had not it been for this fall and the acute aggravation which it induced although it did not induce any significant permanent pathological changes.

"My opinion is thus that even though the patient had a pre-existing condition and changes in her back which would deem [sic] significant and related to her 1989 industrial injury, her need for attention on an acute basis for an acute exacerbation of this condition which occurred on July 23rd, 1990 at Kaiser Hospital was directly related to her fall at Kaiser Hospital."

Based on Dr. Lewis' opinion, we find that neither of claimant's compensable injuries is a material contributing cause of claimant's July 23, 1990 off work fall injury and her hospitalization and treatment arising from that fall. However, Dr. Lewis indicates that after the intervening fall injury had resolved, claimant's low back condition remained materially related to the compensable 1989 injury. Accordingly, we are finding only that the treatment and disability related to the July 23, 1990 fall is not compensable. We note that the intervening fall injury does not break the chain of causation between claimant's accepted condition and her need for continuing treatment related to that condition.

In its respondent's brief, SAIF analyzes this case as an aggravation claim where the major contributing cause of the aggravation is an injury not occurring in the course and scope of employment. On this basis, SAIF argues that the claim is not compensable. However, we note that the 1989 claim was still in open status when the July 1990 fall injury occurred, so there could be no aggravation related to that claim. In regard to the 1988 claim, we have found that the 1988 injury is not a material contributing cause of the July 1990 fall and the ensuing hospitalization.

ORDER

The Referee's order dated March 19, 1992 is affirmed.

November 20, 1992

Cite as 44 Van Natta 2333 (1992)

In the Matter of the Compensation of
ROBERT A. MORRISON, Claimant
WCB Case No. 92-00185
ORDER ON REVIEW
Richard McGinty, Claimant Attorney
Michael Whitty (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of that portion of Referee Brown's order that declined to authorize an offset of overpaid temporary total disability benefits. In his respondent's brief, claimant seeks review of that portion of the order that upheld SAIF's denial of his aggravation claim. On review, the issues are offset and aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of findings number (4) and (6). We replace them with the following findings:

(4) The last arrangement of unscheduled compensation is an October 19, 1990 Stipulation and Order, which awarded, in contemplation of future waxing and waning of low back symptoms, benefits for an additional 10 percent unscheduled disability. The last arrangement of scheduled compensation is a May 16, 1990 Determination Order, which awarded benefits for 20 percent scheduled disability for loss of the right foot (ankle). There is no evidence in the record that the scheduled award of disability contemplated a waxing and waning of ankle symptoms.

(6) On September 12, 1991, a Determination Order reclosed claimant's claim, awarding benefits for temporary total disability through July 26, 1991, the date claimant completed his authorized training program. In the processing of the claim prior to closure, SAIF had paid temporary disability benefits from July 27 through August 8, and August 23 through September 5, resulting in a procedural overpayment of \$939.09.

CONCLUSIONS OF LAW AND OPINIONOffset

The Referee concluded that SAIF had failed to establish an overpayment of temporary total disability benefits. We disagree and reverse.

The September 12, 1991 Determination Order awarded temporary total disability benefits only through July 26, 1991. However, due to normal processing delays in the closure of a claim, SAIF paid claimant \$939.09 in temporary disability benefits beyond that entitlement date. SAIF's payment records, which were received into evidence as Exhibit 23, indicate that a \$494.26 payment was made for "7-26-91 to 8-09-91." Because claimant was entitled to temporary disability benefits for only one of those ten work days included in that period, \$49.43 of the payment was compensation, leaving a \$444.83 overpayment. The payment record also indicates that a \$494.26 overpayment was made for "8-23-91 to 9-06-91." Claimant has not alleged that the payments were not received, and has provided no rebuttal evidence to indicate that SAIF's requested offset has been miscalculated.

After our review of the record, we agree that SAIF has established that \$939.09 in temporary total disability benefits were paid beyond the date claimant was substantively entitled to them. See Eldon E. Hunt, 42 Van Natta 2751 (1990). Accordingly, it is entitled to an offset of those overpaid

benefits against any future awards of permanent disability. Lebanon Plywood v. Seiber, 113 Or App 651 (1992).

Aggravation

Claimant seeks additional compensation for his right ankle condition. The Referee upheld SAIF's denial of the claim, on the basis that there were insufficient objective medical findings of a worsened condition. We disagree.

"Objective findings" in support of medical evidence are defined to include, but are not limited to, "range of motion, atrophy, muscle strength, muscle spasm and diagnostic evidence substantiated by clinical findings." ORS 656.005(19). In Suzanne Robertson, 43 Van Natta 1505 (1991), we examined the legislative history of that definition and concluded that the legislature did not intend to exclude findings based on an injured worker's subjective complaints, but rather require a determination by a physician that an injured worker has a disability or need for medical services. Such a finding, we reasoned, may be based on physically verifiable impairment, but may also be based on the physician's evaluation of the worker's description of pain that he is experiencing.

In this case, Dr. Geist examined claimant and, with respect to the ankle, reported that claimant has a permanent condition that limits his ability to stand or walk for more than two hours in an eight hour period. He added that, due to subjective complaints of pain, claimant is only able to stand on his feet for short periods of time and, consequently, is limited to sedentary work. (Ex. 20A). That report, in our opinion, constitutes medical evidence supported by "objective findings." As in Suzanne Robertson, *supra*, we find that, on the basis of his objective evaluation of claimant's complaints of pain in his right ankle, Dr. Geist concluded that claimant is limited to sedentary work. See also Georgia Pacific Corp. v. Ferrer, 114 Or App 471 (1992). Having found that claimant's last award of compensation (whether the May 1990 Determination Order, the October 1990 Stipulation and Order, or the September 1991 Determination Order) did not contemplate future waxing and waning of his right ankle symptoms, and because claimant was capable of performing light work at the time of the last closure of his claim, we conclude that claimant has established a compensable worsening of his condition and is entitled to additional compensation under ORS 656.273(1).

Claimant is entitled to an assessed attorney fee for prevailing against a denial of compensation. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the aggravation issue is \$2,750, 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 brief and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 31, 1992 is reversed. The SAIF Corporation is authorized to offset overpaid temporary total disability benefits in the amount of \$939.09 against any future awards of permanent disability. SAIF's denial of claimant's aggravation claim for a right ankle 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 concerning the aggravation issue, claimant's attorney is awarded an assessed attorney fee of \$2,750, to be paid by SAIF.

In the Matter of the Compensation of
STEVEN A. SHKILEVICH, Claimant
WCB Case No. 91-10138
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Hallock & Bennett, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of those portions of Referee Menashe's order that: (1) excluded medical reports generated by a physician who was not claimant's attending physician at claim closure; (2) declined to find that temporary standards effective October 1, 1990 and November 20, 1990 are invalid and unenforceable; and (3) increased claimant's uncheduled permanent disability award for a low back injury from 10 percent (32 degrees), as awarded by an Order on Reconsideration, to 15 percent (48 degrees). On review, the issues are evidence, validity of temporary standards, and extent of uncheduled 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

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).

Evidence

We adopt the Referee's reasoning and conclusions regarding the admissibility of Exhibits 17A, 17B, 17C, and 21 with the following supplementation.

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 at claim closure. We disagree.

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).

We recently held 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. Easter M. Roach, 44 Van Natta 1740 (1992). In Roach, we found that such an interpretation was 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 found 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). Easter M. Roach, *supra*.

There is no evidence that Dr. Bralliar, orthopedist, was claimant's attending physician at the time of claim closure. In fact, Dr. Bralliar first examined claimant more than three months after claim

closure. Accordingly, like the Referee, we decline to consider Exhibits 17A, 17B, 17C, and 21 in determining the extent of claimant's unscheduled permanent disability.

On January 24, 1991, a Determination Order issued which awarded permanent disability only for claimant's surgical procedures. If claimant objected to the impairment findings used in rating his disability, his remedy was to request a medical arbiter pursuant to ORS 656.268(7), by noting his objection in his request for reconsideration by the Department. He did not do that. (Tr. 3, 4). Instead, he sought out another physician to provide additional evidence regarding his impairment. As discussed above, such evidence cannot be considered.

Validity of Temporary Standards

At hearing and on review claimant argues that the temporary rules effective October 1, 1990 and November 20, 1990 are invalid and unenforceable. WCD Admin. Orders 15-1990 and 20-1990. We recently rejected that argument in Eileen N. Ferguson, 44 Van Natta 1811 (1992). Therefore, like the Referee, we apply the temporary rules.

Extent of Unscheduled Permanent Disability

The standards in effect on the date of the 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 January 24, 1991, the date the Determination Order issued. WCD Admin. Order 7-1988, as amended by temporary rules adopted effective October 1, 1990 and November 20, 1990 (See WCD Admin. Orders 15-1990 & 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.

The parties do not dispute the values that the Referee assigned to age (1) and education (2). Therefore, we address only the disputed values of impairment and adaptability.

Claimant argues that he is entitled to an increased impairment value based on Dr. Bralliar's reports. As discussed above, we cannot consider these reports. The Referee determined that claimant was entitled to an impairment value of 10 percent. We adopt the Referee's reasoning and conclusions regarding the impairment value.

The Referee determined that claimant was entitled to an adaptability value of 1.5. Claimant argues that his adaptability value should be 2. We agree with claimant.

For workers who have been offered "modified work" or who are working at "modified work" at the "time of determination," an adaptability value is obtained from the matrix of values at former OAR 436-35-310(3)(d) (Temp). Former OAR 436-35-310(3)(a)&(b) (Temp). That matrix compares the physical capacity category of the worker's "regular work" with the physical capacity category of the modified work. The "time of determination" is the mailing date of the Determination Order or Notice of Closure. Former OAR 436-35-005(8) (Temp). "Regular work" means substantially the same job held at the time of injury. Former OAR 436-35-270(3)(a) (Temp). "Modified work" means a job other than that held on the date of injury or that job with substantial modification. Former OAR 436-35-270(3)(b) (Temp).

Here, claimant was still working in the insurance industry at the time of determination. However, his job was substantially modified in that he was unable to do the traveling and claims investigation work that his at-injury job required. (Tr. 8, 17, 18, 19).

In order to determine the appropriate value from the matrix, the physical capacity category for a worker's regular work is obtained from the Selected Characteristics of Occupations Defined in the Dictionary of Occupational Titles (SCODDOT) for the Dictionary of Occupational Titles (DOT) job title which most nearly reflects the duties of the regular work. Former OAR 436-35-310(3)(d) (Temp). The physical capacity category for the modified work is determined from the physical capacities necessary to perform the modified work and the descriptions of physical capacities contained in former OAR 436-35-270(3)(e)-(j) (Temp). Former OAR 436-35-007(10) (Temp).

Here, the DOT job title most accurately reflecting claimant's regular work is claim adjuster (DOT# 241.217-010). The SCODDOT identifies that job as being in the light category. Based on the record, we find that the physical capacity required to perform claimant's modified work was sedentary. (Tr. 17, 18). Therefore, the appropriate adaptability value is 2.

Having determined each of the values necessary under the "standards", claimant's unscheduled permanent disability may be calculated. The sum of the value (1) for claimant's age and the value (2) for claimant's education is 3. The product of that value and the value (2) for claimant's adaptability is 6. The sum of that product and the value (10) for claimant's impairment is 16. Claimant's permanent disability under the standards is, therefore, 16 percent.

ORDER

The Referee's order dated November 20, 1991 is affirmed in part and modified in part. In addition to the Referee's and Order on Reconsideration awards totalling 15 percent (48 degrees) unscheduled permanent disability, claimant is awarded 1 percent (3.2 degrees), giving him a total award to date of 16 percent (51.2 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. The remainder of the order is affirmed.

November 20, 1992

Cite as 44 Van Natta 2337 (1992)

In the Matter of the Compensation of
FRANCIS R. SNYDER, SR., Claimant
WCB Case No. 89-12110
ORDER ON REVIEW
Kosta & Spencer, Claimant Attorneys
Kevin L. Mannix, P.C., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The insurer requests review of Referee Mongrain's order that found that claimant's right knee injury claim was prematurely closed. On review, the issue is premature closure. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact" and "Supplemental Findings of Fact," except for his "Ultimate Finding of Fact," with the following exceptions and supplementation.

We do not find that Dr. Casey's April 4, 1989 opinion that claimant was medically stationary on that date was "conditional on the continued stability of the claimant's condition." (See O&O on recon p. 2).

We do not find that Dr. Casey's post-closure opinion that claimant was not medically stationary on April 4, 1989 is based solely on claimant's continued symptoms post-closure. (See O&O p. 2). Instead, we find that Casey's October 4, 1989 recommendation for surgery and his subsequent opinion regarding claimant's nonstationary status in April 1989 were based on changes in claimant's condition, as well as continuing symptoms. (See O&O on recon p. 1).

FINDING OF ULTIMATE FACT

No material improvement in claimant's compensable condition was reasonably expected on June 15, 1989.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's right knee injury claim was prematurely closed because claimant was not medically stationary on April 4, 1989, the medically stationary date assigned by Evaluation Division, or on June 15, 1989, when a Determination Order closed the claim. We disagree.

Under ORS 656.268(1), claims shall not be closed if the worker's condition has not become medically stationary. "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). It is claimant's burden to prove that he was not medically stationary on the date of closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). In determining whether claimant has carried this burden, we examine medical evidence available at the time of closure, as well as evidence submitted after closure; however, medical evidence submitted after closure that pertains to changes in claimant's condition subsequent to closure is not properly considered. See Scheuning v. J. R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (1987). 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).

In this case, the medical evidence regarding claimant's condition and his prognosis is provided by Dr. Casey, treating physician. On May 3, 1989, Casey opined that claimant was medically stationary at his April 4, 1989 examination. (Ex. 12). After the April examination, claimant returned to work and did not seek treatment again until July 21, 1989, after claim closure. (Ex. 1-5). On October 4, 1989, Casey recommended that claimant undergo a valgus osteotomy, based on continuing symptoms and a "significant change" in claimant's valgus. (Ex. 1-6). Casey considered osteotomy as early as October 1988 (Ex. 1-3); found claimant to be medically stationary in April 1989; and did not recommend osteotomy until October 1989.

Under these circumstances, we do not find that Casey's opinion that claimant was medically stationary on April 4, 1989 was conditional when it issued. Moreover, Casey explained that although he now believes that claimant needed an osteotomy in April 1989, he did not think so then. (See Ex. 26-8). No physician examined claimant between April 4, 1989 and the June 15, 1989 Determination Order. Consequently, Dr. Casey's May 1989 opinion does not persuade us that Casey expected material improvement in claimant's condition at closure.

In determining that the claim was prematurely closed, the Referee relied on Scheuning v. J. R. Simplot & Company, supra, for the proposition that Casey's post-closure opinion is "permissible hindsight" on this issue. In Scheuning, the court noted the worker's testimony that his condition had not changed and the parties' stipulation that the treating doctor was "unaware of any factors that would have made surgery more necessary [after closure] than it was [at closure]." 84 Or App at 625. The court found that the worker's condition did not change between the closure and the subsequent surgery. Id. Noting that the surgery was "treatment that had not been proposed before," the court concluded that the worker was not medically stationary when his claim was closed. Id. at 626.

Here, in contrast, there is evidence that an osteotomy had been previously considered and that changes in claimant's post-closure condition prompted Casper's post-closure opinion that the procedure would be appropriate for claimant. Moreover, we are persuaded by Casey's statement that he would not have opined that claimant was medically stationary in April 1989, if he had thought that surgery would be helpful at that time. Therefore, even assuming that Casey's recent opinion is permissible hindsight, it does not support claimant's cause.

As we have stated, we are persuaded by Casey's May 1989 opinion that claimant was medically stationary in April 1989. Based on that opinion and finding no persuasive evidence to the contrary, we conclude that claimant has not proven that material improvement in his compensable condition was reasonably anticipated on June 15, 1989 when the claim closed. Accordingly, we conclude that claimant

has not carried his burden of proving that his claim was prematurely closed. Inasmuch as premature closure was the sole issue raised at the hearing, we reinstate and affirm the June 15, 1989 Determination Order in its entirety.

ORDER

The Referee's order dated March 13, 1992, as reconsidered April 15, 1992, is reversed. The June 15, 1989 Determination Order is reinstated.

November 23, 1992

Cite as 44 Van Natta 2339 (1992)

In the Matter of the Compensation of
JOHN P. KRONHOLM, Claimant
WCB Case No. 89-16820
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Brazeau and Moller.

The self-insured employer requests review of that portion of Referee Herman's order that increased claimant's uncheduled permanent partial disability award for a back injury from 21 percent (67.2 degrees), as awarded by a Determination Order, to 26 percent (83.2 degrees). On review, the issue is extent of uncheduled permanent partial disability.

We affirm and adopt the Referee's order with the following comment concerning the applicable "standards."

The employer contends that because the hearing on this claim was held on December 6, 1991, the rules adopted by Administrative Order 15-1990 apply to rating claimant's uncheduled permanent partial disability (PPD). The 1990 amendments to ORS 656.283(7) and ORS 656.295(5), which create a different rating principle, do not apply because claimant became medically stationary before July 1, 1990. See Or Laws 1990, Ch. 2, Sec. 54(3). William K. Porter, 44 Van Natta 937 (1992); Stephen A. Roberts, 43 Van Natta 1815 (1991). The Referee properly rated claimant's uncheduled PPD under the standards set out in WCD Administrative Order 6-1988.

Claimant's attorney is entitled to a reasonable assessed fee for his 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 \$800. 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 to claimant.

ORDER

The Referee's order dated December 23, 1991 is affirmed. For services on review, claimant is awarded a reasonable assessed attorney fee of \$800, payable by the self-insured employer.

In the Matter of the Compensation of
EMILIE R. McMURREN, Claimant
WCB Case No. 91-10325
ORDER ON REVIEW
Coons, Cole & Cary, Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Westerband, Kinsley, and Gunn.

Claimant requests review of Referee Gruber's order that upheld the SAIF Corporation's denial of her injury claim for a C3-5 herniated disc condition. On review, the issue is compensability.

We affirm and adopt the Referee's order.

ORDER

The Referee's order dated January 23, 1992 is affirmed.

Board Member Gunn dissenting.

In adopting the Referee's order, it follows that the majority had nothing further to add to the Referee's findings, reasoning, and conclusions. Therefore, it further follows that the majority has also embraced the Referee's reliance on Phil A. Livesley Company v. Russ, 296 Or 25 (1982), in support of their conclusion that claimant has failed to establish a compensable injury arising out of and in the course of employment. I find that inasmuch as the legal analysis is in error, so is the conclusion it purports to support.

Under the Livesley standard, a truly unexplained fall that occurs on the employer's premises while the worker is performing required duties is compensable if the worker can eliminate all idiopathic causes. Moreover, it has consistently been held that the Livesley analysis is only applicable when three requirements are met: (1) a worker falls; (2) an injury results from the fall; and (3) the fall is due to unknown reasons. Folkenberg v. SAIF, 69 Or App 159 (1984); McAdams v. SAIF, 66 Or App 415, rev den 296 Or 638 (1984); Dale E. Holden, 43 Van Natta 2518 (1991); Roxie A. Lingle, 43 Van Natta 1742 (1991).

Here, claimant did not fall and the cause of claimant's condition is known. The medical evidence links claimant's C3-5 herniated disc condition to carrying heavy books simultaneous with a cough incident. Inasmuch as claimant's herniated disc injury did not arise from an unexplained fall, the standard of analyzing compensability, as articulated in Phil A. Livesley, is not applicable. See Folkenberg v. SAIF, supra. Therefore, the majority erred by adopting the Livesley analysis.

In Marshall v. Bob Kimmel Trucking, 109 Or App 101 (1991), the court, citing Larson, distinguished unexplained fall cases from cases in which a claimant sustains an injury due to idiopathic causes. In particular, an "idiopathic" cause is a preexisting physical weakness or disease of the claimant which contributes to the accident. Marshall v. Bob Kimmel Trucking, supra. In other words, the accident does not have to be the sole cause, nor does the claimant have to prove that the injury was caused either by the idiopathic occurrence or the accident. Rather, the court found that awards are uniformly made when the employee's idiopathic condition occurred while working and the obligations of the employee's employment had put the employee in a position where the consequences of the idiopathic occurrence were more perilous than if the employee had not been working. Marshall v. Bob Kimmel Trucking, supra; also see 1 Larson, Workmen's Compensation Law 3-356, 12.12 (1990).

Here, claimant's injuries are the result of an idiopathic cough. Thus, I find that the risk of injury from a cough incident of idiopathic origin was greatly increased by the fact that claimant was carrying heavy books at work for her employer's benefit while she was sick with the flu. See Marshall v. Bob Kimmel Trucking, supra.

This approach, known as the "increased danger rule," was also applied by the Board in Emery A. Reber, 43 Van Natta 2373 (1991). In Reber, the Board found that an injury may be compensable even though idiopathic causes contributed to the injury. To establish compensability under such circumstances, the worker must demonstrate that the injury was related to some work-related risk, although the idiopathic incident itself was not. Professor Larson, in his treatise on workers' compensation law, explains that an injury which occurs due to an at-work incident may be compensable even though it is related to an idiopathic cause:

"Injuries arising out of risks or conditions personal to the claimant do not arise out of the employment unless the employment contributes to the risk or aggravates the injury. When the employee has a preexisting physical weakness or disease, this employment contribution may be found either in placing the employee in a position which aggravates the effect of a fall due to the idiopathic condition, or in precipitating the effects of the condition by strain or trauma." (Emphasis supplied). I Larson, supra, Sec. 12.00 at 3-308 (1985).

I see no reason why this same approach should not be applied to claimant's idiopathic cough incident at issue in the present case. Therefore, to place the risk of loss on the employer due to claimant's idiopathic incident requires a showing of substantial employment contribution to the risk or to the extent of harm. See I Larson, supra, Sec. 12.14(b), at 3-325.

In this case, there is no question that claimant's injury occurred in the course of employment. Claimant was at work as a mailclerk on a "presort day" which involves handling approximately 6,000 pieces of mail that have to be run through an inserter and sorted, in addition to completing the bulk mailing of books and heavy materials. At the time of the injury, claimant was ill due to the flu. She had been sick for a week-and-a-half. Further, she was carrying 10 to 15 pounds of books and she made four trips, up and down stairs, with these stacks of books, to marketing and then back to the mailroom. The weight of these books were resting against her sternum. As claimant was walking down the hall carrying these books, she turned her head and coughed. She felt an immediate stab, a stinging in her left shoulder.

On these facts, I find that such a cough and subsequent pain and injury would not have happened if claimant had not been working in a strenuous capacity while sick with the flu. I would suggest that it was claimant's working on presort day, having to carry heavy books and putting pressure against her chest area that aggravated her flu symptoms and the effect of the cough. Thus, I would find that claimant has established the required "substantial employment contribution" to her injury. See Emery A. Reber, supra.

To drive this point home, I direct the majority to the case of Benefiel v. Waremart Inc., 112 Or App 480 (1992), rev den 313 Or 627 (1992), on rem Martha A. Benefiel, 44 Van Natta 1799 (1992). In Benefiel, claimant had the flu. She went to work in a weakened state because of the flu, and her condition intensified while at work. Her work that day was more hectic and stressful than an average work day. Claimant collapsed to her knee while working. Thereafter, claimant experienced pain in her knee which eventually required surgery. Claimant's employer knew she was ill, yet claimant was required to work and perform stressful work activities.

Here, claimant also had the flu, in fact, on the date of injury, she had been ill for an extended period of time. There is no doubt that she went to work in a diminished state because of her illness. Further, her condition intensified at work as demonstrated by her coughing. She was working on presort day which is more stressful and physically demanding than an average work day. Claimant coughed while carrying heavy books after which she experienced pain and subsequently required surgery. Further, claimant's employer knew she had the flu, yet she was required to work and perform strenuous work activities.

Based on the above analogous facts, I would find that Benefiel is applicable to the case at hand. Thus, I now apply the Benefiel analysis to the present case.

In Benefiel, the Board affirmed the Referee's determination that claimant's knee injury was not compensable. The evidence was undisputed that claimant fainted and fell at work while checking

groceries. The Board found that claimant had failed to meet her burden of showing that the fall was work-related and was not caused solely by a condition personal to claimant.

The Court of Appeals, however, rejected the Referee's and Board's application of Phil A. Livesley in Benefiel on the basis that although claimant met two of the Livesley requirements, i.e., she fell and the fall caused an injury, she had not met the third requirement, that the fall be unexplained. Further, the court held that on the facts presented there was "no evidence" to support the Board's finding that claimant failed to meet her burden of showing that the fall was work-related and was not caused solely by a condition personal to claimant. Benefiel v. Waremart Inc., supra. (Emphasis supplied). Accordingly, the court reversed and remanded the case to the Board.

On remand, the Board reversed its prior decision. After considering claimant's testimony and in light of the court's analysis and conclusions, the Board found that claimant had established that her demanding work activity while in a weakened condition was a material contributing cause of her injury. Martha A. Benefiel, supra at 1799-1800.

Based on similar facts and an application of appropriate law, I believe that the same decision should be arrived at here, without first taking a side trip to the Court of Appeals.

In addition, in the present case, the Referee cited and the majority adopted Jimmy D. Ellis, 42 Van Natta 590 (1990), for the contention that: "An injury resulting from a sneeze or cough which happens to occur at the work place is not compensable." With all due respect to the Referee and the majority, Ellis absolutely does not purport to announce an all-purpose "sneeze or cough rule." Clearly, this would be egregious since there are too many variables that could affect the result. I also note that the facts of Ellis differ from the present case.

In Ellis, while at work, claimant bent over, sneezed and then experienced pain. However, at the time of the incident, claimant was not ill. His work day was not reported as being more demanding than average. In fact, he was in the process of simply bending over. Further, Ellis was argued under the legal theory that his work (in a paint booth) caused his sneeze and not that an idiopathic occurrence was the cause. I also observe that Ellis was decided upon a Phil A. Livesley standard, which, for the reasons previously stated, is not applicable here, and retrospectively, I do not believe applicable in Ellis as there was no unexplained fall.

Therefore, having established legal causation, I turn now to medical causation. I disagree with the Referee's and the majority's conclusion that the medical evidence does not support claimant's claim of compensability. I offer the following reasoning.

The Referee found, as adopted by the majority, that:

"[I]t is impossible to tell to which specific activity or activities Dr. Gallo was referring to when she stated 'It is my opinion that her work activities on April 11, 1991, would be considered an accidental injury materially contributing to her condition.' It is unclear whether Dr. Gallo considered the incident involving claimant's cough or sneeze when the pain first arose as a "work activity." Opinion at 3.

I do not find this statement to be supported by the record.

When Dr. Gallo, treating surgeon, examined claimant on May 17, 1991, she noted that: "The patient states that she works carrying mail and in that capacity was carrying some mail about five weeks ago and coughed and sneezed very vigorously. She experienced a sudden twinge of pain in the left shoulder area." (Ex. 5-1). (Emphasis supplied). Then, Dr. Gallo opined that "the overwhelming majority of [claimant's] symptoms and deficit are referable to a large central disc herniation at C4-5 which I think is the result of her on-the-job injury of 4-11-91." (Emphasis supplied). Dr. Gallo's opinion clearly specifies the activities which she was referring to and which she found to be the material contributing cause to claimant's accidental injury and subsequent condition. Moreover, at a later date, Dr. Gallo reiterated and reinforced this same opinion that claimant's work activities of "walking down the hall at work with her arms wrapped around a stack of books and coughed and felt a sharp pain in the left shoulder area simultaneous with the coughing" was "an accidental injury materially contributing

to her condition." (Ex. 9). Further, Dr. Morris adopted Dr. Gallo's findings and concurred with her opinion.

Accordingly, I find no support for the Referee's and majority's conclusion that it is "impossible" to discern which work activities Dr. Gallo and Dr. Morris are referring to. Not only do I not find it "impossible," I do not find Drs. Gallo's and Morris' opinions to be incomplete or poorly reasoned. However, I do find several reasons to discount the opinion of Dr. Woolpert, independent medical examiner.

Dr. Woolpert stated that: "The causative episode is interesting to note that none of the first three physicians who saw the patient stated anything in respect to a work injury." (Ex. 12-5). It appears that Dr. Woolpert relied quite significantly on this finding in making his determination in regards to causation. However, a review of the evidence shows that Dr. Woolpert's reliance is misplaced, because his finding is not supported.

Claimant first saw a physician on April 15, 1991, at McKenzie-Willamette Hospital. The emergency room physician reported that claimant had a "recent history 'flu symptoms' with cough." (Ex. 2A-1). He also noted that claimant "worked, PHA mailroom" after which claimant complained of "increased pain." (Id). Additionally, Dr. Woolpert also stated that the first doctor that claimant saw was Dr. Waugh. This is incorrect. The emergency room physician that claimant saw on April 15, 1991 was Dr. Dean. See Exhibit 2A-1. Dr. Waugh is a physician claimant saw the following day due to a vasovagal reaction to the prescription drug, Hydrocodone. See Exhibit 3.

The second physician claimant saw was Dr. Morris. On April 18, 1991, Dr. Morris noted that claimant had been ill for over one-and-a-half weeks. Dr. Morris also reported that claimant "could well have a cervical disc protrusion on the left, probably from coughing." (Ex. 3A). Subsequently, he expressly concurred with Dr. Gallo's finding that claimant's injury was attributable in a material way to her April 11, 1991 work activity of carrying mail and simultaneously coughing.

Finally, the third physician that claimant saw was Dr. Sharrer on April 22, 1991, who referred claimant to Dr. Gallo. (Ex. 5). However, inasmuch as the medical reports of Dr. Sharrer were not admitted into evidence, Dr. Woolpert's opinion on them is not persuasive, and should not be considered, especially in light of his significant errors, as addressed above.

Dr. Woolpert also stated that in his experience, he has seen a ruptured disc due to coughing on a repetitive basis. However, Dr. Woolpert never took a history, nor did any other doctor in the record, that claimant had experienced coughing on a "repetitive basis." Therefore, his opinion is merely speculative and thus, insufficient to establish that claimant's cough incident alone was the cause of her injury. See Gormley v. SAIF, 52 Or App 1055 (1981); Julia Pate'-Harper, 43 Van Natta 275, 277 (1991).

The final discrepancy of Dr. Woolpert's opinion, is that Dr. Woolpert only considered whether the coughing incident or a later lifting incident caused claimant's injury. Dr. Woolpert, unlike Drs. Gallo and Morris, did not address the effects of claimant's coughing while ill with the flu and carrying heavy books. Therefore, I do not find his opinion to be complete or well reasoned, but rather based on inaccurate facts and speculation.

Accordingly, the Referee and the majority erred by finding Dr. Woolpert to be the more persuasive opinion. Rather, I would rely on the treating surgeon, Dr. Gallo's opinion. She was in the best position to assess claimant's condition and the causative factors. She addressed the central causation issue. Her opinion is based on accurate facts and Dr. Morris concurs with her opinion. Therefore, I find no reason not to defer to the opinion of the treating surgeon.

Inasmuch as the medical evidence preponderates in claimant's favor and the only two cases relied upon by the Referee and adopted by the majority, are not applicable in the present case, I cannot come to any other conclusion but that claimant has met her burden of proof.

Lastly, I note that the primogenitor of course and scope cases, Jordan v. Western Electric, 1 Or App 441 (1970), has a firm message that ought not be diluted, nor taken lightly, and I steadfastly believe

should be abided by. Citing Livingston v. State Ind. Acc. Com., 200 Or 468, 472-73 (1954), the Jordan court stated:

"This court has uniformly held that provisions of the Workmen's Compensation Law should be interpreted liberally in favor of the workman, and particularly should this be so when we are confronted with a "borderline case". In the interests of justice, and to carry out the humane purposes of the Compensation Law, all reasonable doubts should be resolved in favor of the workman." Jordan v. Western Electric, *supra* at 447.

In light of the facts before me, coupled with applicable law, I cannot come to any other conclusion than a finding of compensability. Therefore, I have no choice, but to dissent.

November 23, 1992

Cite as 44 Van Natta 2344 (1992)

In the Matter of the Compensation of
DELORES A. WOLFE, Claimant
 WCB Case Nos. 91-08161 & 91-06360
 ORDER ON REVIEW
 Royce, et al., Claimant Attorneys
 Tooze, et al., Defense Attorneys
 Steve Cotton (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Moller.

The SAIF Corporation requests review of Referee Lipton's order which: (1) set aside its denials of claimant's medical services and aggravation claims for a low back and right leg condition; and (2) upheld the Hartford Insurance Company's (Hartford) denial of claimant's "new injury" claim for the same conditions. 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

Finding that claimant had not sustained a new occupational disease while Hartford was on the risk, the Referee concluded that SAIF remained responsible for claimant's condition. We agree that responsibility remains with SAIF. Therefore, we adopt the Referee's "Opinion and Conclusion" with the following supplementation.

SAIF contends that claimant's compensable 1988 injury is not the major contributing cause of her current condition. See ORS 656.005(7)(a)(B). We disagree.

Dr. Davis, claimant's treating physician, specifically opined that claimant's April 1988 on-the-job injury was the major contributing cause of claimant's current condition and need for medical treatment. Dr. Struckman essentially concurred with this opinion, concluding that claimant's symptoms were in no way related to her current work activity, but if anything, related to her compensable motor vehicle accident of April 1988.

SAIF argues that, in deposition, Dr. Struckman stated that the only significant pathology that he had noted on claimant's CT scan was some mild foraminal narrowing which is attributable to the degenerative process. SAIF further argues that Dr. Struckman thought that the CT scan findings "would not be related to any work activity, any car wreck or anything else." (Ex. 70-10).

In response, claimant notes that Dr. Struckman's opinion was offered in response to a hypothetical based on potential findings. (Ex. 70-13). Moreover, claimant notes that when Dr. Struckman was specifically asked whether his opinion had changed since July 8, 1991, when he opined that

claimant's symptoms were in no way related to her work activity but instead to her 1988 compensable motor vehicle accident, Dr. Struckman replied: "Correct. My opinion has not changed." (Ex. 70-10).

Under such circumstances, we find that claimant's 1988 compensable injury with SAIF is the major contributing cause of her current condition. Therefore, we conclude that claimant has established the compensability of her current condition. Having established the compensability of claimant's current disability, we proceed to a determination of responsibility.

Subsequent to the Referee's order, we held in Donald C. Moon, 43 Van Natta 2595 (1991), that a carrier responsible for a compensable injury remains responsible for continued or increased disability during employment covered by a later carrier, unless claimant sustains a new injury or occupational disease during the subsequent employment. See ORS 656.308. If a prior carrier can establish that a claimant's subsequent work activities were the major contributing cause of a worsening of the disease, responsibility shifts to the subsequent carrier. ORS 656.308; 656.802(2); Donald C. Moon, *supra*.

Here, Dr. Davis reported that since claimant's compensable April 1988 injury with SAIF, claimant has had periodic symptomatic aggravations brought on by various on-the-job activities, innocuous activities or, often, by no particular activity at all. Moreover, Dr. Davis indicated that he concurred with Dr. Struckman's opinion that, as of July 1991, claimant's symptoms were in no way related to her work activity.

Accordingly, we are not persuaded that claimant's post-January 1, 1990 work activities while Hartford was on the risk were the major contributing cause of a worsening of her underlying condition. See ORS 656.802(2); Donald C. Moon, *supra*. Inasmuch as SAIF has not established that claimant sustained a new occupational disease while Hartford was on the risk, SAIF remains responsible for claimant's low back and right leg condition. ORS 656.308; Donald C. Moon, *supra*.

Claimant is entitled to an assessed attorney fee for prevailing against SAIF's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is \$1,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and statement of services), the complexity of the issue, and the value of the interest.

ORDER

The Referee's order dated December 4, 1991 is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee in the amount of \$1,500, to be paid by the SAIF Corporation.

November 23, 1992

Cite as 44 Van Natta 2345 (1992)

In the Matter of the Compensation of
NANCY A. WORTH, Claimant
WCB Case No. 91-15273
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Podnar's order that awarded 23 percent (34.5 degrees) scheduled permanent partial disability for loss of function of claimant's right hand, whereas an Order on Reconsideration had awarded 25 percent (37.5 degrees). In her Reply Brief, claimant argues that the Referee erred in refusing to admit proposed Exhibit 15, a December 12, 1991 report by claimant's treating physician. In its brief, the self-insured employer argues that the Referee erred in refusing to admit Exhibit 16, a January 1992 check-the-box response whereby claimant's treating physician concurred with an August 14, 1991 report by Dr. Button. In the event that the latter report is

admitted and considered, the employer further contends that claimant's permanent disability award should be reduced. 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

Evidentiary matters

The Referee declined to admit two post-Reconsideration Order medical reports, because they were not regarded as clarifying the medical situation. On review, claimant argues that the Referee erred in failing to admit proposed Exhibit 15, a December 1991 report by Dr. Hardiman, claimant's treating physician, and the self-insured employer argues that the Referee erred in failing to admit proposed Exhibit 16, a January 1992 check-the-box response whereby Hardiman concurred with an August 14, 1991 report by Dr. Button.

At the outset, we note that claimant initially argued the merits of the extent issue as though Hardiman's December 1991 report was in evidence. Upon realizing that the report had not been admitted, claimant raised her evidentiary objection for the first time in her Reply Brief. Claimant did not argue that Exhibit 15 should or should not be admitted at hearing. Assuming without deciding that claimant's evidentiary objection is properly before us on review, we nevertheless conclude that both medical reports, proposed Exhibits 15 & 16, were properly excluded.

We review the Referee's evidentiary ruling for abuse of discretion. See ORS 656.283(7); James D. Brusseau II, 43 Van Natta 541 (1991).

ORS 656.268(5) allows the submission of corrective reports and any medical evidence that should have been but was not submitted by the attending physician at the time of claim closure. See Agnes C. Rusinovich, 44 Van Natta 1544, corrected 44 Van Natta 1567 (1992). However, medical evidence, from the attending physician, offered pursuant to ORS 656.268(5), must be submitted "at the reconsideration proceeding." ORS 656.268(5); Gary C. Fischer, 44 Van Natta 1597 on recon 44 Van Natta 1655 (1992). Finally, with the exception of a medical arbiters' report pursuant to ORS 656.268(6)(a), any medical evidence generated after an Order on Reconsideration is not admissible. ORS 656.268(7); ORS 656.283(7); Gary C. Fischer, supra; Tor J. East, 44 Van Natta 1654 (1992); Teresa L. Erp, 44 Van Natta 1728 (1992).

Here, although the proposed Exhibits 15 and 16 are from claimant's attending physician, they were generated months after the August 28, 1991 Order on Reconsideration. Thus, they are not admissible. Gary C. Fischer, supra; Tor J. East, supra; Teresa L. Erp, supra. Accordingly, we conclude that the Referee did not abuse his discretion by refusing to admit the disputed evidence.

Extent of scheduled permanent disability

The parties agree that, if the disputed evidence is not admissible for the purpose of determining claimant's permanent disability award, the Referee's 23 percent award is accurate. In view of the parties' agreement and the fact that the post-reconsideration medical evidence is not admissible, we do not disturb the Referee's award.

ORDER

The Referee's order dated February 11, 1992 is affirmed.

In the Matter of the Compensation of
WILLIAM J. BEACHY, Claimant
WCB Case No. C2-02576
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Rick W. Roll, Claimant Attorney
David Lillig (Saif), Defense Attorney

Reviewed by Board Members Moller and Brazeau.

On October 16, 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.

The submitted disposition agreement originally provided that "the parties have agreed to settle claimant's claim for compensation and payments of any kind due or claimed for all past, present, and future conditions, exception compensable medical services, FOR SAIF'S CORPORATION'S WAIVING OF ALL THIRD-PARTY LIEN RIGHTS, EQUAL TO AN APPROXIMATE DOLLAR VALUE OF \$26,630."

The parties have submitted an addendum, which among other things, provides that "SAIF Corporation's lien rights to this settlement have a value of \$21,888.89." All parties have signed the addendum. Under the circumstances, we find that it is the intent of the parties to settle this matter for a total consideration of a waiver of third party lien rights in the amount of \$21,888.89. The agreement, as supplemented by the addendum, is in accordance with the terms and conditions prescribed by the Director. See ORS 656.236(1). Accordingly, the claim disposition agreement is approved as amended by the November 20, 1992 addendum.

IT IS SO ORDERED.

November 24, 1992

Cite as 44 Van Natta 2347 (1992)

In the Matter of the Compensation of
MARIANNE CAMP, Claimant
WCB Case No. 90-04776
ORDER ON REVIEW
Patrick Lavis, Claimant Attorney
Charles Ringo, Defense Attorney

Reviewed by Board Members Hooton and Moller.

The insurer requests review of Referee Menashe's order that set aside its denial of claimant's claim for her psychological condition. Claimant cross-requests review of that portion of the Referee's order that awarded a \$5,000 attorney fee for her counsel's services at hearing. On review, the issues are compensability 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 relied upon the opinion of Dr. Satterwhite, claimant's treating psychologist, and found that claimant had established compensability of her psychological condition. We adopt the Referee's "Opinion and Conclusions" on the compensability issue, with the following supplementation.

On review, the insurer contends that the Referee should not have relied upon Dr. Satterwhite's opinion, as Dr. Satterwhite was not fully informed of the disciplinary action taken against claimant

during her employment. The insurer argues that Dr. Satterwhite's lack of information on that subject is apparent by his response in deposition that he was not aware of "specific information" regarding claimant's problems with reversing numbers, dispatching the fire department to the wrong address, and failing to dispatch officers to an incident at the local newspaper.

However, Dr. Satterwhite testified that he was aware of claimant's reprimand for her use of certain language. He knew that, as a result, claimant had been taken out of the dispatcher position and put in a clerical position. Dr. Satterwhite also knew of a three-page letter that claimant received after the incident. Dr. Satterwhite was aware of claimant's problem with transposing numbers, and he knew of letters put into claimant's file regarding citizen complaints over her failure to dispatch officers to the local newspaper. Finally, Dr. Satterwhite was aware of meetings that resulted between claimant and her supervisors concerning claimant's job performance.

We conclude that, although Dr. Satterwhite was apparently not informed about the specifics of every incident over the course of claimant's employment as a dispatcher, he was aware that claimant had problems with the performance of her duties. He was also aware of her re-assignment, her evaluations, her written reprimand, and the complaints filed against her. We find that his knowledge of these factors is sufficient to support a conclusion that Dr. Satterwhite was aware of the problems at work and did not consider them to be a significant factor in her psychological condition.

Accordingly, we affirm the Referee on the issue of compensability.

Attorney fees/Hearing

On review, claimant contends that the Referee's attorney fee award of \$5,000 for services at hearing is not adequate. After reviewing the record, claimant's statement of services, and the factors set forth in OAR 438-15-010(4), we agree that the Referee's attorney fee should be increased. In particular, we note that this matter involved two full days of hearing, a deposition of Dr. Satterwhite, multiple settings, a voluminous record, and a significant risk that claimant might not prevail. We therefore increase claimant's attorney fee for services at hearing to \$7,500, which we find to be reasonable.

Attorney fees/Board

Claimant is entitled to an assessed attorney fee for successfully defending against the insurer's request for review on the issue of compensability. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services on Board review is \$700, to be paid by the insurer. In reaching this conclusion, we have particularly considered the complexity of the issue, the time devoted to the case (as represented by claimant's statement of services) and the value of the interest involved. We note that claimant is not entitled to an attorney fee for that portion of his counsel's services devoted to the attorney fee issue.

ORDER

The Referee's order dated October 10, 1991 is affirmed in part and modified in part. In lieu of the Referee's attorney fee award, for services at hearing, claimant is awarded a reasonable assessed attorney fee of \$7,500, to be paid by the insurer. The remainder of the Referee's order is affirmed. For services on review, claimant is awarded an attorney fee of \$700, payable by the insurer.

In the Matter of the Compensation of
FILOGONIA REYES-CRUZ, Claimant
WCB Case No. 91-14282
ORDER ON REVIEW
Francesconi & Associates, Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Moller and Brazeau.

The insurer requests review of those portions of Referee Davis' order that: (1) increased claimant's unscheduled permanent disability award from 9 percent (28.8 degrees), as awarded by an Order on Reconsideration, to 21 percent (67.2 degrees) for her right shoulder condition; and (2) set aside the insurer's denial of claimant's aggravation claim for her current right shoulder condition. On review, the issues are extent of unscheduled permanent disability and aggravation. 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 disability

We adopt the Referee's Conclusions of Law and Opinion on the issue of extent, with the following supplementation.

On review, the insurer argues that the Referee incorrectly assigned claimant a value for adaptability. The insurer contends that the Orthopaedic Consultants released claimant for regular work and she is, therefore, not entitled to a value for adaptability. We disagree.

The Consultants' report of January 8, 1991 contains the following question regarding claimant's capabilities: "Do you feel (claimant) is capable of returning to light duty, modified or regular work?" The Consultants responded:

"Yes, she is capable of light duty or modified work, as the case may be. There should be some restrictions on the amount of activity for a short period of time with respect to the right shoulder."

The Consultants also explained that specific restrictions would be difficult but claimant could probably perform certain work-related motions "to the point of pain."

Under the circumstances, we agree with the Referee that the Consultants did not release claimant to regular work. We conclude that, although the Consultants did not specify the restrictions to be placed upon claimant, the Consultants did recognize that she would be limited from performing her normal tasks due to pain. Accordingly, we agree that claimant is entitled to a value for adaptability.

Aggravation

The Referee concluded that claimant established a compensable aggravation claim for her current right shoulder condition. We disagree.

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement or award of compensation. ORS 656.273(1). To prove a compensable worsening of her unscheduled condition, claimant must show that increased symptoms or a worsened underlying condition caused her 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 contends that, because she was diagnosed with an impingement syndrome by Dr. Thomas after the Determination Order, she has established a compensable aggravation. However, we are not persuaded that the impingement syndrome diagnosis is evidence of a worsening. Before the Determination Order, claimant had experienced shoulder problems which were diagnosed as rotator cuff syndrome or tendinitis. She received injection therapy which provided some relief from her symptoms. (Ex. 28-2). Following closure, claimant continued to experience the same problems and experienced similar relief from her symptoms after receiving injections. (Ex. 35-3, 55). Dr. Thomas did not first examine claimant until after claim closure. Under these circumstances, we are not convinced that the impingement syndrome diagnosed after closure by Dr. Thomas is evidence of a new condition or a worsening since claim closure.

Furthermore, we do not find that claimant has proven that she was less able to work after the time of the Determination Order. Prior to closure, claimant was working on a sporadic, part-time basis of approximately two hours per week. (Ex. 28-3). Following closure, claimant was working approximately two hours per day and was capable of working in the sedentary range. (Ex. 32 B-1; 35-1). Under the circumstances, we conclude that claimant has failed to establish that, since the time of the April 1991 Determination Order, she has sustained a loss of earning capacity.

Because we find that claimant has failed to establish a worsened condition since the time of the Determination Order, we reverse the Referee on the issue of aggravation. The Referee's assessed attorney fee is also reversed.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that \$750 is a reasonable assessed fee for claimant's counsel's efforts on review concerning the issue of extent. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by that portion of claimant's respondent's brief), the complexity of the issue presented and the value of the interest involved.

ORDER

The Referee's order dated March 17, 1992 is reversed in part and affirmed in part. That portion of the Referee's order that set aside the insurer's aggravation denial is reversed. The insurer's August 27, 1991 denial is reinstated and upheld. The Referee's attorney fee award of \$1,900 is also reversed. The remainder of the Referee's order is affirmed. For services on review concerning the issue of extent of permanent disability, claimant's counsel is awarded an assessed attorney fee of \$750, to be paid by the insurer.

November 24, 1992

Cite as 44 Van Natta 2350 (1992)

In the Matter of the Compensation of
STEPHEN SCHAFF, Claimant
WCB Case No. 91-09431
ORDER ON RECONSIDERATION (REMANDING)
Burt, Swanson, et al., Claimant Attorneys
Cooney, Moscato, et al., Defense Attorneys

The insurer requests reconsideration of our October 29, 1992 Order on Review, which remanded this matter to the Referee for the admission of claimant's request for reconsideration of the November 14, 1990 Determination Order. The insurer contends that remand is not warranted, because claimant failed to establish that the document was not obtainable with due diligence at the time of hearing. We disagree.

ORS 656.295(5) provides, in part:

"The review by the board shall be based upon the record submitted [by the referee] and such oral and written argument it may receive. * * * However, if the board

determines that a case has been improperly, incompletely or otherwise insufficiently developed or heard by the referee, it may remand the case to the referee for further evidence taking, correction or other necessary action."

That statute requires this Board to complete a two-step process when a party requests review and remand of an order for the taking of additional evidence. First, we must review the record and determine whether the case has been "improperly, incompletely or otherwise insufficiently developed." If so, we must then exercise our discretion to determine whether remand is warranted. See Bailey v. SAIF, 296 Or 41 (1983). In this regard, we have refused to grant a request for remand where the moving party has failed to establish that the material evidence was not obtainable with due diligence at the time of hearing. See e.g., Penni L. Mumm, 42 Van Natta 1615 (1990); see also Compton v. Weyerhaeuser Co., 301 Or 641 (1986).

In this case, however, neither the insurer nor claimant has requested remand for submission of additional evidence. Rather, we concluded remand is necessary in light of our recent decision in Olga I. Soto, 44 Van Natta 697, recon den 44 Van Natta 1609 (1992), which relies on a party's request for reconsideration in order to determine the validity of the Order on Reconsideration. Without that document, this case has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Because neither party at the initial hearing had reason to believe that claimant's request for reconsideration would play such a significant role in determining the issues raised, we believe that remand is appropriate in this case, regardless of the document's actual availability at the time of hearing.

We withdraw our October 29, 1992 Order on Review (Remanding) On reconsideration, as supplemented herein, we adhere to and republish our October 29, 1992 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

November 25, 1992

Cite as 44 Van Natta 2351 (1992)

In the Matter of the Compensation of
KRISTINE M. CARTMELL, Claimant
WCB Case No. 91-03493
ORDER ON RECONSIDERATION
Schneider & DeNorch, Claimant Attorneys
Meyers & Radler, Defense Attorneys

On November 19, 1992, we affirmed the Referee's order that: (1) reduced claimant's unscheduled permanent disability award from 9 percent (28.8 degrees), as awarded by Determination Order, to 7 percent (22.4 degrees); and (2) granted the self-insured employer's request to offset its overpayment of unscheduled permanent disability against any future permanent disability awards. On our own motion, we withdraw our November 19, 1992 order for reconsideration.

The Referee's offset authorization was permitted by ORS 656.268(13). In addition, we have previously held that our authority, as well as that of the Hearings Division, to allow recovery of overpaid compensation is not confined by, and exists independently of, ORS 656.268(13). Steven F. Sutphin, 44 Van Natta 2126 (1992); Steve E. Maywood, 44 Van Natta 1199 (1992).

Accordingly, on reconsideration, we adhere to and republish our November 19, 1992 order, as supplemented herein. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Member Hooton dissenting.

I continue to disagree with the majority's affirmance of the Referee's offset authorization for the reasons set forth in my dissenting opinion.

In the Matter of the Compensation of
KELLY M. DAVIS, Claimant
WCB Case No. 91-12878
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of Referee Brazeau's order that: (1) denied its motion to dismiss for lack of subject matter jurisdiction; and (2) set aside a March 7, 1991 Determination Order as premature. In the event the Board finds that his claim had not been prematurely closed, claimant contends that he is entitled to an award of permanent disability and has established a compensable worsening of his condition since the March 7, 1991 Determination Order. On review, the issues are jurisdiction, premature closure and, alternatively, extent of disability and aggravation. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Preliminary Issues

Before we address the primary matters on review, we must address two preliminary issues raised by the parties. First, claimant notes several clerical errors in the "Evidentiary Rulings" portion of the Referee's order and requests clarification as to what exhibits are included in the hearing record. The insurer does not oppose the request. After our review, we find the following exhibits were admitted into evidence at hearing and are in fact included in the hearing record: Exhibits 1-20, inclusively, Exhibits A, 3A, 5A, 5B, 5BB, 5C, 8A, 14A, 14B, 16A, 16B, 16C, 17A, 18A, 18B, 20A and 21. The insurer withdrew Exhibits 18C, 18D and 19A and, consequently, were not admitted into the record.

The second preliminary issue concerns whether the Referee should have deferred resolution of the premature closure issue. Citing Gary L. Waldrupe, 44 Van Natta 702 (1992), the insurer contends that consideration of that issue must await the final resolution of a dispute concerning claimant's request for a change of attending physician. We disagree.

In Waldrupe, the claimant requested a hearing on the insurer's denial of his claim for medical services and additional compensation for a worsened condition. The insurer denied the claim, in part, because the requesting physician was not the attending physician. We held that, while the Hearings Division lacked jurisdiction to consider the attending physician dispute, the aggravation issue was a matter concerning a claim and, as such, entitled the claimant to a hearing under to ORS 656.283(1). We concluded, however, that the hearing should be deferred pending the Director's resolution of the attending physician dispute:

"[I]n the present case, claimant's reopening request was contingent on whether Dr. Puziss' surgery request should be authorized. Since elective surgery requests can only be made by an attending surgeon, the viability of Dr. Puziss' request is dependent on whether he is an attending physician under ORS 656.245(3)(a). Consequently, it follows that the consideration of any claim reopening must await the Director's determination as to whether claimant may change his attending physician to Dr. Puziss." 44 Van Natta at 704. (Citation omitted; emphasis supplied).

As in Waldrupe, the insurer here refuses to recognize a medical provider as an attending physician. In fact, this case involves the same medical provider, Dr. Puziss. However, contrary to the insurer's assertion, the issue whether claimant was medically stationary at the time of claim closure is not contingent upon Dr. Puziss' status as an attending physician. As the insurer itself recognizes, the resolution of the medically stationary date is primarily a medical question to be decided on competent medical evidence. See Harmon v. SAIF, 54 Or App 121 (1981). Because Dr. Puziss is entitled to render

an opinion on that issue regardless of whether he is an attending physician, we find no reason why the resolution of this matter should be postponed.

Premature Closure

The Referee concluded that claimant's left shoulder injury claim had been prematurely closed by a March 7, 1991 Determination Order. After our review of the record, we agree and adopt the Referee's conclusion and reasoning. We add the following supplementation.

On review, the insurer argues that, in finding premature closure, the Referee erred in considering medical evidence from Dr. Puziss that addressed claimant's condition after closure. We agree that subsequent changes in claimant's condition are not considered in determining whether a claim was prematurely closed. See Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985). In this case, however, the evidence establishes that claimant's condition did not change between the date of closure and the time of Dr. Puziss' reports. Claimant testified that his condition between February 1991 and May 1991 was unchanged and that his shoulder remained "sore and aggravated." (Tr. 33). His testimony is supported by the medical record, which documents that he demonstrated ongoing shoulder pathology prior to and after closure. Accordingly, contrary to the insurer's contention, the Referee properly considered Dr. Puziss' medical reports to conclude that claimant's condition was not yet medically stationary at the time of closure. See Scheuning v. J.R. Simplot & Company, 84 Or App 622 (1987).

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 premature closure 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 April 16, 1992 is affirmed. For services on Board review concerning the premature closure issue, claimant's counsel is awarded an assessed attorney fee of \$1,000, to be paid by the insurer.

November 25, 1992

Cite as 44 Van Natta 2353 (1992)

In the Matter of the Compensation of
NELDA L. GILBERT, Claimant
WCB Case No. 91-02955
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Terrall & Associates, Defense Attorneys

Reviewed by Board Members Moller and Brazeau.

The insurer requests review of Referee Baker's order that set aside its denial of claimant's disc herniation claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant began work performing physical labor in a retail business warehouse commencing in August 1989. On October 22, 1990, claimant compensably injured her right wrist. She returned to work the following day at which time her wrist symptoms worsened. She was examined by a physician who instructed claimant not to lift with her right arm. She returned to work the following day, October 24. Her work activity at that time involved opening cases of merchandise and scanning the "bar codes" on the merchandise. Some of the cases were stapled and glued shut and were, therefore, difficult to open. Because of the right wrist injury, she concentrated her work activity on the left side.

The next day, on October 25, claimant experienced symptoms in her neck, left shoulder and back. Her symptoms worsened with activity. On November 30, 1990, she sought treatment from Dr. Levy, M.D., who diagnosed a back strain secondary to overuse from work. (Ex. 19-1). However, when an MRI scan revealed degenerative disc disease at C5-6 and lateral disc bulging at C6-7, Dr. Levy referred claimant to Dr. Hacker, neurosurgeon, for evaluation. (*Id.*)

Dr. Hacker performed a cervical myelogram, which confirmed his diagnosis of a cervical disc herniation at C6-7 left. (Ex. 23-1). On May 7, 1991, Dr. Hacker performed a cervical microdiscectomy with inner body fusion at C6-7. (Ex. 29-1). Dr. Hacker's surgery disclosed an acute compression of the nerve root caused by a frank herniation.

Claimant's condition arose during a discrete period of time. She had experienced no prior problems with her neck or left shoulder. The occurrence of her herniated cervical disc was unexpected. Claimant's work activity on October 25 and 26, 1990 materially contributed to the disabling compression of the nerve root which necessitated the surgery.

CONCLUSIONS OF LAW AND OPINION

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

At hearing, claimant's attorney stated that there was an issue as to whether the claim should be analyzed as an industrial injury, occupational disease, or consequential condition. (Tr. 2). The Referee addressed the claim as an industrial injury. The insurer asserts that the claim properly is analyzed as an occupational disease or consequential condition. We agree with the Referee.

Occupational diseases are distinguished from accidental injuries in that the onset of the former is gradual over a long period of time, rather than within a relatively short, discrete period of time. Further, occupational diseases are not unexpected but recognized as an inherent risk of continued exposure to conditions of the particular employment. Valtinson v. SAIF, 56 Or App 184, 187-88 (1982). A consequential condition is one that develops as a result of a compensable injury. See ORS 656.005(7)(a)(A); Albany General Hosp. v. Gasperino, 113 Or App 411 (1992).

Claimant's symptoms and need for treatment were due to an acute disc herniation. Claimant was able to identify a two-day period during which she experienced the onset of symptoms. Despite having performed manual labor during a significant portion of her work history, claimant had experienced no prior problems with her neck or shoulder. Dr. Hacker, claimant's treating surgeon, has opined that claimant's job activities during this two-day period were a material contributing cause of the occurrence of her disc herniation. We, therefore, conclude that claimant's condition occurred during a short, discrete period and was not expected. Compare United Pac. Reliance Inc. v. Banks, 64 Or App 644 (1983) and Valtinson v. SAIF, 56 Or App 184 (1982) with Taylor v. Multnomah Co. School District, 109 Or App 499 (1991). Accordingly, we conclude that the Referee properly analyzed claimant's claim as an industrial injury.

Moreover, we find no persuasive evidence that claimant's cervical herniation is the result of preexisting degenerative disease or a consequence of her accepted wrist injury; rather she has established that her claim is compensable as an industrial injury under ORS 656.005(7)(a). We note in this regard that Dr. Reimer, an independent medical examiner with the Orthopaedic Consultants, reported that if, at surgery, Dr. Hacker identified an acutely protruded soft cervical disc rather than osteophyte formation as being responsible for compression of the nerve root, then "one would be more inclined to think that this was an injury related to [claimant's] work situation and not a progressive degenerative process that might have pre-existed." (Ex. 38). Dr. Hacker's surgery, in fact, disclosed that a herniated disc, rather than degenerative disc disease and osteophyte formation, was responsible for claimant's nerve root compression. Therefore, we agree with the Referee's conclusion that, in addition to claimant's treating physician, the independent medical examiners also lend support to claimant's 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 \$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 and statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 7, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of \$1,200, to be paid by the insurer.

November 25, 1992

Cite as 44 Van Natta 2355 (1992)

In the Matter of the Compensation of
NINFA HERNANDEZ, Claimant
WCB Case No. 90-18231
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Moller.

Claimant requests review of that portion of Referee Emerson's order that upheld the SAIF Corporation's denial of her right ankle and low back injury claim. In its brief, SAIF disagrees with those portions of the Referee's order that: (1) awarded claimant temporary disability benefits from August 9, 1990 through September 25, 1990; and (2) awarded claimant a penalty and related attorney fee for SAIF's allegedly unreasonable failure to pay temporary disability benefits. On review, the issues are compensability, temporary disability benefits 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

Compensability

We adopt the Referee's "Conclusions and Opinion" on the issue of compensability.

Temporary disability benefits

The Referee concluded that, whether or not claimant's injury claim was compensable, SAIF nonetheless had a duty to pay interim compensation until it either accepted or denied the claim. He therefore directed SAIF to pay claimant interim compensation from August 9, 1990, through September 25, 1990, the date upon which SAIF denied the claim. We reverse.

In Bono v. SAIF, 298 Or 405 (1984), the Court referred to Jones v. Emanuel Hospital, 280 Or 147 (1977), and stated that the purpose of interim compensation is to compensate the injured worker for leaving work, even where this results from a non-compensable injury, as in Jones. However, the Court also held that, if the worker does not demonstrate that he or she left work due to the injury, interim compensation is not required. Bono v. SAIF, *supra*; see also ORS 656.262(4); ORS 656.210(3).

Here, the Referee found, and we agree, that claimant's services had been terminated by the employer prior to her injury. Although she may have been injured at her former employer's workplace, claimant was voluntarily assisting her husband (who was a worker for the employer) and she had no expectation of being reimbursed. Accordingly, at the time she was injured, there were no wages being earned by claimant that should have been replaced by the payment of interim compensation. Furthermore, claimant had already been laid off and, therefore, cannot demonstrate that she left work due to the injury. See Donna R. Ruegg, 41 Van Natta 2207 (1989).

Under the circumstances, we find that the facts of this case do not trigger SAIF's duty to pay claimant interim compensation benefits until the time her claim was denied. We, therefore, reverse the Referee on the issue of entitlement to temporary disability benefits.

Because we have reversed the Referee's award of temporary disability benefits and concluded that SAIF, in this case, was under no obligation to pay claimant interim compensation benefits as she had not left work as a result of the injury, we find that SAIF's conduct in refusing to pay such benefits was not unreasonable. Consequently, we reverse the Referee's award of a penalty and related attorney fee for SAIF's allegedly unreasonable failure to pay interim compensation.

ORDER

The Referee's order dated December 31, 1991 is reversed in part and affirmed in part. Those portions of the Referee's order that directed the SAIF Corporation to pay claimant temporary disability benefits from August 9, 1990 through September 25, 1990 and awarded an attorney fee from this increased compensation, are reversed. The Referee's penalty and attorney fee award for SAIF's allegedly unreasonable failure to pay temporary disability benefits is also reversed. The remainder of the Referee's order is affirmed.

November 25, 1992

Cite as 44 Van Natta 2356 (1992)

In the Matter of the Compensation of
CHERYL L. HURLIMAN, Claimant
WCB Case No. 91-16833
ORDER ON REVIEW
Westmoreland, et al., Claimant Attorneys
Mitchell, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of those portions of Referee Crumme's order that: (1) increased claimant's award of 6 percent (9 degrees) scheduled permanent disability for the loss of use or function of the left forearm, as awarded by Stipulation and Order, to 5 percent (9.6 degrees) scheduled permanent disability for the loss of use or function of the left arm; and (2) awarded no scheduled permanent disability, in addition to the 7 percent (10.5 degrees) scheduled permanent disability award for the loss of use or function of the right forearm. 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, the issues are extent and rate of scheduled permanent disability. We reverse in part and affirm in part.

Extent

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

Claimant seeks additional awards of scheduled permanent disability for his left and right arms based on a medical evaluation which occurred after issuance of the Order on Reconsideration. (See Exs. 35, 36). This evaluation, though it may present a claim for aggravation, is not relevant to the rating of claimant's disability as of the time of the Order on Reconsideration. See ORS 656.283(7); George Schukow, 44 Van Natta 2125 (1992); Grace M. Nyburg, 44 Van Natta 1875 (1992); Teresa L. Erp, 44 Van Natta 1728 (1992). Accordingly, the Referee properly declined to consider them.

Rate

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 March 20, 1992 is reversed in part and affirmed in part. Those portions of the order that directed it to pay claimant's scheduled permanent disability award at the rate of \$305 per degree and approved an attorney fee payable from that increased compensation are reversed. The remainder of the order is affirmed.

November 25, 1992

Cite as 44 Van Natta 2357 (1992)

In the Matter of the Compensation of
LISA A. HYMAN, Claimant
WCB Case No. 91-03726
ORDER OF ABATEMENT
Welch, Bruun & Green, Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

The SAIF Corporation has requested reconsideration of our November 6, 1992 Order on Review.

In order to allow sufficient time to consider the motion, the above noted Board order is abated and claimant is requested to file a response to the motion within 14 days.

IT IS SO ORDERED.

November 25, 1992

Cite as 44 Van Natta 2357 (1992)

In the Matter of the Compensation of
DUANE L. LEAFDAHL, Claimant
WCB Case No. 91-12828
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Moller and Brazeau.

Claimant requests review of those portions of Referee Hoguet's order that: (1) increased his scheduled permanent disability award from 6 percent (8.1 degrees) for loss of use or function of the right foot (ankle) to 10 percent (13.5 degrees); and (2) declined to assess penalties and attorney fees for the insurer's allegedly unreasonable refusal to pay the disability award at the rate of \$305 per degree. The insurer cross-requests review of those portions of the Referee's order that: (1) increased claimant's scheduled permanent disability award; and (2) directed it 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 partial disability, and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Extent of Scheduled Permanent Disability

The Referee increased claimant's scheduled permanent disability award from 6 percent to 10 percent. Claimant asserts that he is entitled to an award of 19 percent. The insurer seeks a reduction to 6 percent, the amount awarded by the Determination Order.

We affirm and adopt that portion of the Referee's order finding that claimant was entitled to 6 percent scheduled permanent disability, with the following supplementation.

We first note that, in determining extent of scheduled permanent disability, the Referee found that the temporary rules contained in WCD Admin. Orders 15-1990 and 20-1990 were invalid and instead applied the rules promulgated in WCD Admin. Order 6-1988. Subsequent to the Referee's order, we concluded that we have no authority to declare the temporary standards to be invalid. Eileen N. Ferguson, 44 Van Natta 1811, 1812 (1992). Instead, we are statutorily required to apply the standards adopted by the Director at the relevant time. Id. at 1813. In this case, the applicable standards are those contained in WCD Admin. Orders 15-1990 and 20-1990, as well as 6-1988.

Claimant asserts that he is entitled to impairment for chondromalacia and the surgery performed for that condition. Claimant contends that, although the standards did not provide impairment values for chondromalacia and the surgery, claimant is entitled to such awards "outside of the standards."

Since the Referee's order, the Director has promulgated a rule providing an impairment value for chondromalacia. (WCD Admin. Order 11-1992). Even assuming it is applicable to this matter, however, claimant would not be entitled to impairment for his chondromalacia since the rule requires that such a condition qualify as grade IV and there is no evidence claimant's condition is of such severity. OAR 436-35-230(13)(b)(A). Therefore, we find no basis for awarding impairment values for claimant's chondromalacia or surgery.

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).

Penalty and Attorney Fee

Because claimant is not entitled to be paid scheduled permanent disability compensation at the rate of \$305 per degree, the insurer has not delayed or otherwise resisted the payment of compensation due claimant. No penalty or related attorney fee can be assessed.

Finally, claimant's attorney is entitled to an assessed attorney fee since the insurer cross-requested review of the extent of disability issue and we did not reduce the amount of compensation awarded by the Referee. 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 regarding this issue is \$500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue, the complexity of the issue, and the value of interest to claimant.

ORDER

The Referee's order dated January 23, 1992 is affirmed in part and reversed in part. That portion of the order that directed the insurer to pay claimant's scheduled permanent disability award at the rate of \$305 per degree and awarded an attorney fee payable from this increased compensation is reversed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of \$500, to be paid by the insurer.

November 25, 1992

Cite as 44 Van Natta 2359 (1992)

In the Matter of the Compensation of
BILLY R. MARLNEE, Claimant
 WCB Case No. 91-12463
 ORDER OF DISMISSAL
 Schultz & Taylor, Claimant Attorneys
 Julene M. Quinn (Saif), Defense Attorney

Claimant requested, and the SAIF Corporation cross-requested, review of Referee Barber's order that awarded claimant additional temporary partial and temporary total disability. The parties have submitted a proposed "Stipulation and Disputed Claim Settlement," which is designed to resolve all issues raised or raisable in this matter. Specifically, the parties agree that claimant shall receive \$2,500 (less a \$500 attorney fee) to resolve the issue of claimant's entitlement to additional temporary disability beyond March 26, 1991.

Pursuant to the settlement, the parties agree that their respective requests for Board review shall be dismissed with prejudice. We have approved the agreement, thereby fully and finally resolving this dispute.

We recognize that since the parties' dispute pertains to temporary disability, there is no "bona fide dispute over compensability of a claim." See ORS 656.289(4). Therefore, notwithstanding the document's title of "Disputed Claim Settlement," the parties' agreement does not qualify as such a settlement. Rather, the agreement represents a stipulation providing for the payment of additional temporary disability beyond March 26, 1991 totalling \$2,500 (less a \$500 attorney fee). Consequently, our approval of the agreement has been granted based on this interpretation.

Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

November 25, 1992

Cite as 44 Van Natta 2359 (1992)

In the Matter of the Compensation of
DAVID R. MURFIN, SR., Claimant
 WCB Case No. 91-08361
 ORDER ON REVIEW
 Michael B. Dye, Claimant Attorney
 Lundeen, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Holtan's order that dismissed his request for hearing on the ground that claimant had abandoned his hearing request based on a failure to attend three separately scheduled independent medical examinations. On review, the issue is the propriety of the Referee's dismissal.

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

This matter was initially set for hearing on September 26, 1991. That hearing was subsequently postponed at the insurer's request. Claimant asserts that the Referee postponed the hearing based on his conclusion that claimant's theory of compensability had changed from one of injury to occupational disease. Claimant contends that the Referee improperly postponed the hearing because, contrary to the Referee's conclusion, no new theory of compensability was raised at hearing by claimant. Claimant argues on review that we should remand this matter to the Referee to convene a hearing based on the evidentiary record in existence on the initial date set for hearing.

We review the Referee's interim decision to postpone the hearing for abuse of discretion. Based on the record here, we conclude that the Referee's postponement of the hearing was not an abuse of discretion. In this regard, claimant's 801 claim form referred to a May 6, 1991 incident which resulted in instant pain. (Ex. 1). Claimant's treating physician, Dr. Paulson, refers to a May 6, 1991 onset of symptoms. (Ex. 3). A subsequent MRI report refers to a "[l]ifting incident on 5/6/91." (Ex. 3). The insurer denied "an injury * * * sustained on or about 5/6/91." (Ex. 6) Under these circumstances, we cannot conclude that the Referee's earlier decision to postpone the hearing in this matter was an abuse of discretion. See OAR 438-06-031 and 438-06-081(4).

ORDER

The Referee's order dated May 27, 1992 is affirmed.

November 25, 1992

Cite as 44 Van Natta 2360 (1992)

In the Matter of the Compensation of
ELIZABETH A. RICE, Claimant
 WCB Case No. 91-09539
 ORDER ON RECONSIDERATION
 Peter O. Hansen, Claimant Attorney
 Charles Lundeen (Saif), Defense Attorney

On September 24, 1992, we withdrew our September 17, 1992 order for reconsideration. We took this action to consider the effect, if any, the parties' waiver of any procedural challenges to the Director's Order on Reconsideration had on our decision that the Director's Order on Reconsideration was invalid because it was issued prior to the Director's consideration of the medical arbiters' report.

The parties have now submitted a proposed "Stipulated Settlement," which is designed to resolve all issues raised or raisable in this case, in lieu of the Referee's order. Pursuant to the stipulation, the parties agree that claimant's scheduled permanent disability award shall be paid at a rate of \$145 per degree unless and until there is an ultimate appellate determination providing that awards such as claimant's shall be paid at a rate of \$305 per degree. The parties further stipulate that all issues raised or raisable are dismissed with prejudice.

We have approved the parties' stipulation, thereby fully and finally resolving this dispute, in lieu of all prior orders. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

November 25, 1992

Cite as 44 Van Natta 2360 (1992)

In the Matter of the Compensation of
KATHRYN R. SHAW, Claimant
 WCB Case No. 92-04761
 ORDER DENYING RECONSIDERATION
 Charles Lundeen, Defense Attorney

On October 16, 1992, we dismissed claimant's request for review on the ground claimant had not established that notice of her request was timely provided to the other parties. Our order further provided that this untimeliness finding would remain unless claimant established otherwise. Finally, we

advised the parties that our order would become final within 30 days unless one of the parties sought judicial review.

On November 18, 1992, we received a November 16, 1992 handwritten letter from claimant. The letter includes her affidavit stating that she "mailed the appropriate papers in a timely manner" to the other parties. We treat claimant's submission as a motion for reconsideration. Inasmuch as our October 16, 1992 order has become final by operation of law, we are without authority to reconsider our decision.

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

Here, our order was mailed to the parties on October 16, 1992. In dismissing claimant's request for review, our order notified the parties that our order would become final within 30 days.

The 30th day from October 16, 1992 is November 15, 1992, a Sunday. Therefore, the final day for reconsideration or appeal of our October 16, 1992 order was Monday, November 16, 1992. ORCP 10A; ORS 174.120; Anita L. Clifton, 43 Van Natta 1921 (1991).

Claimant's letter was dated and mailed to the Board on November 16, 1992. Had we received that letter prior to the expiration of the aforementioned 30-day period, we would have made every effort to reconsider our decision within that period. In any event, claimant's letter was not received until November 18, 1992, more than 30 days after our October 16, 1992 order. Under such circumstances, we are without authority to reconsider our order as claimant requests.

As noted in our prior decision, we are mindful that claimant has requested reconsideration 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. Nevertheless, notice that our October 16, 1992 order would become final within 30 days of its issuance was clearly stated in our order. Finally, we are not free to overlook a statutory requirement.

Accordingly, the request for reconsideration of our October 16, 1992 order is denied.

IT IS SO ORDERED.

November 25, 1992

Cite as 44 Van Natta 2361 (1992)

In the Matter of the Compensation of
LINDA J. SMITH, Claimant
WCB Case Nos. 91-10738 & 91-17996
ORDER DENYING RECONSIDERATION
Welch, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

On November 12, 1992, we dismissed Argonaut Insurance Company's request for Board review of a Referee's order that: (1) set aside its denials of claimant's aggravation claim for her current right shoulder condition; and (2) upheld United Employers' Insurance's denial of claimant's aggravation claim for the same condition. This action was taken in conjunction with our approval of a Disputed Claim Settlement (DCS) between claimant and Argonaut. Contending that its interests have been "very significantly affected by the reversal" of the Referee's order, United Employers seeks rescission of our order and the resumption of the briefing schedule. We deny United Employer's request.

A claimant may settle her rights to benefits with one carrier and, in so doing, accept the possibility that she will not receive compensation from the remaining carriers. See E.C.D. Inc. v.

Snider, 105 Or App 416 (1991); Jack Spinks, 43 Van Natta 1351 (1991), aff'd mem Spinks v. Mosley and Sons et al, 112 Or App 661 (1992).

Here, in entering into the DCS with Argonaut, claimant has accepted just such a possibility. Moreover, because Board jurisdiction over this matter hinged on Argonaut's appeal and since that appeal has been dismissed, that possibility has become a reality since we are without authority to alter other portions of the Referee's decision.

In this regard, we disagree with United Employers' assertion that we "reversed" the Referee's decision insofar as it pertained to the upholding of United Employers' denial. To the contrary, only those portions of the Referee's decision which related to claimant and Argonaut were replaced by the approved DCS. That portion of the Referee's order which upheld United Employers' denial stands unaltered. Inasmuch as such an action has no significant effect on the interests of United Employers, we decline to rescind our approval of the DCS.

Accordingly, we deny the request for reconsideration. The parties' rights of appeal shall continue to run from our November 12, 1992 order.

IT IS SO ORDERED.

November 25, 1992

Cite as 44 Van Natta 2362 (1992)

In the Matter of the Compensation of
STEPHEN R. SUNDSTROM, Claimant
 WCB Case Nos. 91-10774 & 91-10757
 ORDER ON REVIEW
 Pozzi, et al., Claimant Attorneys
 Susan Ebner (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of that portion of Referee Galton'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 those portions of the Referee's order that: (1) increased claimant's scheduled permanent disability award for a right foot injury from 2 percent (2.7 degrees), as awarded by an Order on Reconsideration, to 13 percent (17.55 degrees); (2) affirmed an Order on Reconsideration award of 17 percent (54.40 degrees) unscheduled permanent partial disability for a low back injury; and (3) reversed an Order on Reconsideration award of 5 percent (16 degrees) unscheduled permanent disability for a pelvic injury. On review, the issues are rate and extent of scheduled permanent disability 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

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).

Extent of Scheduled Disability--Right Foot

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 or Notice of Closure control the evaluation of permanent partial disability. OAR 436-35-003.

In this case, the Order on Reconsideration awarded claimant benefits for 2 percent scheduled permanent disability for loss of the right foot. The Referee concluded that the award was incorrect, stating that: "Excluding a separate chronic condition rating, I conclude that claimant is entitled to a total right foot award of 13 percent." (O & O at 4). We agree with the Referee's conclusion, but provide the following rating of the extent of claimant's scheduled permanent partial disability:

Loss of subtalar inversion--20 degrees retained; <u>former</u> OAR 436-35-190(2). (Ex. 35A-2).	2%
Loss of ankle dorsiflexion--10 degrees retained; <u>former</u> OAR 436-35-190(6). (Ex. 35A-3).	4%
Loss of ankle plantar flexion--35 degrees retained; <u>former</u> OAR 436-35-190(8). (Ex. 35A-4).	2%
Partial loss of plantar sensation; <u>former</u> OAR 436-35-200(1). (Ex. 37A-4).	5%

The range of motion losses are added for a total of 8 percent. That figure is then combined with other losses of the right foot, for a total award of 13 percent scheduled permanent partial disability. Former OAR 436-35-190(11). Because that impairment award exceeds 5 percent, claimant is not entitled to a separate award for a chronic condition. Former OAR 436-35-010(8)(a); (WCD Admin. Order 20-1990).

Extent of Unscheduled Disability--Low Back

The Order on Reconsideration awarded claimant benefits for 17 percent unscheduled permanent disability. The Referee concluded that the award was correct. Again, we agree with the Referee's conclusion, but provide the following rating.

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

Age and Education

The appropriate value for claimant's age of 40 years is 1. Former OAR 436-35-290.

The appropriate value for claimant's 11 years years of formal education is 1. Former OAR 436-35-300(3).

The highest specific vocational pursuit (SVP) level demonstrated by a claimant during the ten years preceding the date of determination is used to determine a value for skills. Former OAR 436-35-300(4). For our purposes, permanent disability is always determined on the date of hearing. The position which claimant successfully performed during the ten years preceding the date of hearing, which has the highest specific vocational pursuit (SVP) level, was a carpenter (DOT # 860.381-022). Therefore, the appropriate value for skills is 1. Former OAR 436-35-300(4).

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

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

Adaptability

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

Here, claimant is not working as a result of his compensable injury and no offer of employment has been made. Claimant's physical capacity is in the light to medium category with restrictions. Therefore, the appropriate adaptability value is 2.5. Former OAR 436-35-310(4).

Impairment

Claimant is entitled to the following impairment values:

Compression Fracture, L3; <u>Former</u> OAR 436-35-350(1).	3%
Loss of Flexion--70 degrees retained; <u>former</u> OAR 436-35-360(6).	2%
Loss of Extension--10 degrees retained; <u>former</u> OAR 436-35-360(7).	2%
Loss of lateral flexion--25 degrees retained bilaterally; <u>former</u> OAR 436-35-360(8).	2%

The values for lost range of motion are added for a total award of 9 percent. Former OAR 436-35-360(10). Again, because that impairment award exceeds 5 percent, claimant is not entitled to a separate award for chronic condition.

Computation of Unscheduled Permanent Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value 1 is added to his education value 1, the sum is 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 9, the result is 16.5 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the "standards" is, therefore, 17 percent.

Rate of Unscheduled Disability--Pelvic Injury

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

ORDER

The Referee's order dated February 27, 1992 is affirmed in part and reversed in part. That portion 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 from this increased compensation is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
JOHN L. WELCH, JR., Claimant
WCB Case No. 91-16129
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Terrall & Associates, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Spangler's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a shoulder and arm 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

On review, claimant contends that the Referee applied an incorrect legal standard to determine compensability of his claim. Claimant argues that, because the Referee found that claimant suffered from a preexisting condition, the Referee should have applied the standard set forth in ORS 656.005(7)(a)(B). See Bahman M. Nazari, 43 Van Natta 2368 (1991). However, because claimant's claim is for an occupational disease rather than an industrial injury, we conclude that ORS 656.005(7)(a)(B) is not applicable. See Lizbeth Meeker, 44 Van Natta 2069 (1992).

In order to establish a compensable occupational disease, the worker must prove that a disease was caused, or an underlying condition was worsened, in major part by work activities. ORS 656.802(2). The Referee found that claimant had a preexisting shoulder and arm condition and that his claim failed because he had not proved that work activities had worsened the condition. Claimant disputes that his shoulder and arm condition was preexisting and asserts that he proved compensability. We conclude that, whether or not claimant's condition preexisted his employment, compensability was not established.

In 1988, before claimant began work with the employer, claimant sought treatment for shoulder and arm symptoms from the Oregon Health Sciences University (OHSU). Claimant was eventually diagnosed with "possible bilateral inflammatory arthritis of the shoulders." (Ex. 5-1).

In October 1990, claimant began working for the employer. In July 1991, he again sought treatment for shoulder and arm symptoms from Dr. Janzen, M.D., who eventually diagnosed bilateral shoulder arthritis and mild carpal tunnel syndrome. (Ex. 9). Dr. Janzen reported that claimant's:

"shoulder pain has been gradually worsening over the two years prior to seeing me in July of 1991. I believe the primary cause of [claimant's] development of arthritis in both shoulders, was the heavy lifting of auto parts that he was doing for a number of years. There would be no other major reason for [claimant] to develop such significant arthritis at such a young age[.] * * *

"I am not aware of [claimant] having sought care from another doctor four years ago for his shoulder. He did not relate that to me during any of the visits that we had. * * * I doubt that the symptomatology he had four years ago has any major relevance to his current status and disability. * * *

In August 1991, Dr. Janzen referred claimant to Dr. Wells, M.D., for a second opinion. Dr. Wells reported that claimant's symptoms had begun eight months earlier and noted a "previous history of difficulty referable to his shoulder" about "three to four years ago" when he sought treatment at OHSU. (Ex. 12-1,-2). Dr. Wells diagnosed "pain syndrome involving the shoulders, hands, and wrists" and found him "significantly depressed" and "over-reacting to the pain." (Id. at 3).

Dr. Wells later concurred in a letter written by the employer's attorney stating that, at the time of his initial examination, he had not seen any medical reports but since had reviewed the records from OHSU and concluded that "it appears [claimant's] condition in 1988 was the same as his condition now." (Ex. 17-1). Dr. Wells also found that the cause of claimant's condition was "multifactorial" with the two "most significant factors" being "the emotional component and the pre-existing shoulder problems". (*Id.*) Dr. Wells, therefore, found it "impossible to identify any one factor as the major contributing cause of the current condition." (*Id.* at 2).

In the event of a dispute between medical experts, 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, we find that the opinion of Dr. Janzen is, first, based on erroneous information in that he indicated that claimant had worked lifting auto parts for the employer for a "number of years". Claimant had been working for the employer only for nine months when he sought treatment from Dr. Janzen. Since Dr. Janzen based his opinion regarding causation on his understanding of the length of claimant's employment, we give his opinion less weight.

Furthermore, Dr. Janzen indicated that he had not been aware of claimant's prior treatment for shoulder and arm symptoms in 1988. Although Dr. Janzen's report also indicated that claimant's attorney informed him of this treatment, there is nothing in the record demonstrating the specific information given to Dr. Janzen. Consequently, we also find that Dr. Janzen's opinion is based on an incomplete history.

Having determined that Dr. Janzen's opinion is entitled to less weight, we conclude that claimant failed to prove a compensable claim for an occupational disease since Dr. Wells' opinion indicated that claimant's condition was due to multiple factors and that it was impossible to determine the major contributing cause. Therefore, the claim fails.

ORDER

The Referee's order dated March 10, 1992 is affirmed.

November 27, 1992

Cite as 44 Van Natta 2366 (1992)

In the Matter of the Compensation of
KATHY BOTT, Claimant
 WCB Case No. 91-16747
 ORDER ON REVIEW
 Philip Schuster II, Claimant Attorney
 Lundeen, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

Claimant requests review of Referee Spangler's order that: (1) precluded an independent medical examination report from consideration of claimant's impairment; and (2) affirmed an Order on Reconsideration awarding 5 percent (6.75 degrees) scheduled permanent disability for loss of use or function of claimant's right ankle. Claimant also asserts that the Order on Reconsideration was invalid because no medical arbiter had been appointed by the Director. On review, the issues are validity of the Order on Reconsideration, evidence, and extent of scheduled permanent disability.

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

Validity of Order on Reconsideration

When a party requests reconsideration of a Determination Order or Notice of Closure on the basis of a disagreement with the impairment findings used in the rating of disability, the Order on Reconsideration may be voided by that party if the Director fails to comply with ORS 656.268(7) and appoint a medical arbiter. *Randy M. Mitchell*, 44 Van Natta 2304 (1992); *Olga I. Soto*, 44 Van Natta 297, 700 (1992).

Claimant asserts that the present Order on Reconsideration is invalid because she disagreed with the impairment findings used in rating her disability, but a medical arbiter was not appointed by the Director. We conclude that the record does not support claimant's contention.

Claimant's request for reconsideration indicated that she disagreed only with the rating of her permanent disability. (Ex. 23). Such a disagreement is not sufficient to require the appointment of a medical arbiter. Rather, in order to void the present order, claimant would have had to disagree with the impairment findings used in rating that disability. See e.g. Doris C. Carter, 44 Van Natta 769 (1992). Because she did not do so, the Director was not required to appoint a medical arbiter. The Order on Reconsideration is valid.

Evidence

In determining claimant's extent of disability, the Referee declined to consider the findings of Dr. Coletti, an orthopedist who conducted an independent medical examination prior to claim closure. Claimant challenges this conclusion, asserting that under OAR 436-35-007(9), such evidence should have been considered. We disagree.

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). Further, impairment findings made by a consulting physician or other medical provider at the time of claim closure may be used to determine impairment only if the attending physician concurs with the findings. Former OAR 436-35-007(8) (WCD Admin. Order 2-1991). Therefore, we have found that an independent medical examiner's impairment findings cannot be used for purposes of rating disability in the absence of the attending physician's concurrence with those findings. Easter M. Roach, 44 Van Natta 1740 (1992).

Here, there is no dispute that Dr. Coletti was not the attending physician. Moreover, the attending physician, Dr. Bald, expressly did not concur in the entirety of Dr. Coletti's report. (Ex. 19). Consequently, the Referee correctly did not consider Dr. Coletti's report in determining impairment.

In asserting that the report should have been considered, claimant relies on former OAR 436-35-007(9), which provides that "[i]mpairment is determined by the attending physician except where a preponderance of medical opinion establishes a different level of impairment." To be consistent with ORS 656.245(3)(b)(B), this rule is most reasonably construed in conjunction with former OAR 436-35-007(8). That is, we find that the reference to "medical opinion" is limited to those reports with which the attending physician concurred. Therefore, we disagree with claimant's construction of the standards as allowing for consideration of Dr. Coletti's impairment findings.

Extent of Scheduled Disability

Claimant next asserts that she is entitled to scheduled chronic condition impairment, relying on the report of Dr. Coletti and her own testimony. See former OAR 436-35-010(6). As discussed above, we do not consider Dr. Coletti's findings regarding impairment. Furthermore, claimant's testimony, by itself, is not sufficient to establish chronic condition impairment. Angela Weeks, 44 Van Natta 1650 (1992). Therefore, claimant has failed to prove impairment on this basis.

Claimant further contends that she is entitled to impairment under former OAR 436-35-200(4), which in part provides that,

"[w]hen a preponderance of objective medical evidence indicates an accepted compensable injury to the foot has resulted in a permanent inability to walk or stand for greater than two hours in an 8-hour period, the award shall be 15% of the foot."

Dr. Bald indicated that claimant could work 8 hours a day with the "use of stool to allow her to rest her ankle regularly." (Ex. 16). We find no evidence in this restriction that Dr. Bald considered claimant to be unable to walk or stand for more than 2 hours in an 8-hour shift. Therefore, we find that claimant's argument in this regard also fails.

ORDER

The Referee's order dated March 9, 1992 is affirmed.

In the Matter of the Compensation of
FIDEL D. CHAVEZ, Claimant
WCB Case No. 91-08427
ORDER ON REVIEW
Hollis Ransom, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Podnar's order which dismissed his request for hearing. On review, the issue is the propriety of the Referee's dismissal order. We affirm.

FINDINGS OF FACT

We adopt the first three paragraphs of the Referee's Dismissal Order as our Findings of Fact, although we correct the cited date of claimant's request for hearing. Claimant's first hearing request is dated June 28, 1991.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that he was without jurisdiction in this matter. We agree and add the following supplementation.

We conclude that, inasmuch as claimant's first hearing request was filed before the issuance of the Director's Order on Reconsideration, the request was premature and did not bestow jurisdiction on the Hearings Division to consider the subsequently issued Order on Reconsideration. See Barr v. EBI, 88 Or App 132 (1987); Naught v. Gamble, Inc., 87 Or App 145 (1987); Lorna D. Hilderbrand, 43 Van Natta 2721 (1991).

Noting that an Order on Reconsideration did not issue within its statutory deadline, claimant contends that he was entitled to seek a hearing because of the Director's inaction. We acknowledge that the Director apparently failed to perform his statutory obligations within the requisite time period. Nevertheless, although the failure to comply with a statute may subject the Director to mandamus, it would not deprive the Director of the power to act. See Lyday v. Liberty Northwest Insurance Corporation, 115 Or App 663 (1992). (Referee's failure to issue an order within 30-day statutory time period does not deprive referee of power to act). Since the Hearings Division's review authority under ORS 656.268(6)(b) is expressly contingent on the issuance of a reconsideration order and because claimant requested a hearing prior to the issuance of that order and, following the eventual issuance of that order, did not request a hearing within the requisite 180-day appeal period, we agree with the Referee that the Hearings Division was without authority to consider claimant's appeal.

ORDER

The Referee's March 27, 1992 order of dismissal is affirmed.

November 27, 1992

Cite as 44 Van Natta 2368 (1992)

In the Matter of the Compensation of
ROBERT G. EDWARDS, Claimant
WCB Case No. 91-12120
ORDER ON REVIEW
Quintin B. Estell, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Moller and Brazeau.

Claimant requests review of Referee Herman's order that: (1) set aside an Order on Reconsideration as invalidly issued; (2) determined that jurisdiction to consider the issues of premature claim

closure and extent of temporary/permanent disability rested with the Director; and (3) declined to leave the record open for consideration of two post-hearing depositions. On review, claimant contends that: (1) the Referee had jurisdiction to resolve the premature closure issue; (2) the Referee erred in refusing to permit the introduction of the post-hearing depositions; and (3) the claim was prematurely closed.

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

In vacating the Order on Reconsideration, the Referee reasoned that jurisdiction remained with the Director because, despite claimant's disagreement with the medical findings concerning his impairment, the reconsideration order had issued without the appointment of a medical arbiter or consideration of a medical arbiter report. The Referee relied on Olga I. Soto, 44 Van Natta 697, recon den 44 Van Natta 1609 (1992).

Contending that the failure to appoint a medical arbiter has no impact on the premature closure issue, claimant argues that the Referee was authorized to resolve that question. We disagree.

A Referee has authority to rescind a determination order or notice of closure should the claim be found to have been closed prematurely. ORS 656.283(7). Nevertheless, in order for the Referee to retain jurisdiction to make such a determination, an objecting party must request a hearing from a reconsideration order. ORS 656.268(6)(b).

Here, claimant sought a hearing from a reconsideration order. Among other issues, claimant raised the issues of premature closure and extent of permanent disability. Thus, the Referee initially had authority to consider the issues resulting from the reconsideration order.

However, since the reconsideration order issued without the completion of the mandatory medical arbiter proceedings, the Referee appropriately held that the reconsideration order was invalid. Once the reconsideration order was declared invalid, the condition precedent for the Referee's consideration of the premature closure issue (a validly issued reconsideration order) was eliminated. Consequently, jurisdiction to consider any and all issues arising from the Determination Order (including premature claim closure) currently remains with the Director.

In light of our conclusion that the Referee properly determined that jurisdiction to resolve the substantive issues of premature closure and extent of disability rested with the Director, we hold that the Referee did not abuse her discretion in refusing to hold the record open for the introduction of post-hearing depositions. Inasmuch as these substantive issues were not ripe for adjudication, the Referee was within her discretion in declining to continue the proceeding to secure further evidence pertaining to those matters.

ORDER

The Referee's order dated June 2, 1992 is affirmed.

November 27, 1992

Cite as 44 Van Natta 2369 (1992)

In the Matter of the Compensation of
MICHAEL L. FARRIS, Claimant
WCB Case No. 91-15696
ORDER ON REVIEW
Roger D. Wallingford, Claimant Attorney
Charles Lundeen, Defense Attorney

Reviewed by Board Members Brazeau and Kinsley.

Claimant requests review of Referee Podnar's order which affirmed an Order on Reconsideration awarding 5 percent (7.5 degrees) scheduled permanent disability for loss of function of the left arm. On review, claimant also moved to remand the case to the Referee to consider further medical evidence in rating his impairment. On review, the issues are motion to remand and extent of scheduled permanent disability. We deny the motion and affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINIONMotion to Remand

Claimant requests that we consider the April 15, 1992 report of his attending physician, Dr. Seyfer, as evidence in establishing claimant's impairment. We treat this request as a motion to remand to the Referee for additional evidence.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Olson, 37 Van Natta 1054, 1055 (1986), aff'd mem., 80 Or App 152 (1986). We consider the proffered evidence only to determine whether remand is appropriate.

We do not consider the present record, without Dr. Seyfer's April 15, 1992 report rating claimant's impairment, to be improperly, incompletely, or insufficiently developed concerning the extent of claimant's scheduled permanent disability. Claimant's claim was closed by a Notice of Closure issued August 5, 1991. (Ex. 20). Claimant requested reconsideration, and an Order on Reconsideration issued October 23, 1991. (Ex. 23). We have previously held that medical reports pertaining to claimant's condition after the date of the Order on Reconsideration are not relevant to rating claimant's disability. Teresa L. Erp, 44 Van Natta 1728 (1992); see also ORS 656.268(7). Therefore, we find that the proffered evidence is not relevant to rating the extent of claimant's disability. See ORS 656.283(7); OAR 436-30-050(4)(f). Accordingly, claimant's motion to remand is denied.

Extent of Scheduled Permanent Disability

We adopt the Referee's order affirming the October 23, 1991 Order on Reconsideration.

ORDER

The Referee's order dated February 21, 1992 is affirmed.

November 27, 1992

Cite as 44 Van Natta 2370 (1992)

In the Matter of the Compensation of
CAROL F. HUCKABY, Claimant
 WCB Case No. 91-15293
 ORDER ON REVIEW
 Black, et al., Claimant Attorneys
 Schwabe, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Brazeau.

Claimant requests review of Referee Nichols' order that: (1) set aside an Order on Reconsideration on the ground that it was void; and (2) found that the matter remained with the Appellate Unit of the Workers' Compensation Division (WCD). In their briefs, both parties requested, alternatively, that we remand this matter to the Referee for a decision on the merits. On review, the issues are the validity of the WCD's Order on Reconsideration and remand. We affirm with supplementation and deny the motion to remand.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINIONValidity of Department's Order

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 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 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). Furthermore, we more recently held in Brenton R. Kusch, 44 Van Natta 2222 (1992), that unless a party whom the mandatory provision is intended to protect waives that mandatory procedure, the Order on Reconsideration is not valid for review.

Here, claimant requested reconsideration of the Notice of Closure 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 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). Moreover, at hearing, claimant was not willing to waive the appointment of an arbiter. (Tr. 6).

Where, as here, 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; Brenton R. Kusch, supra. Accordingly, the Referee correctly set aside the Order on Reconsideration.

Although the Referee concluded that the Order on Reconsideration was void, we also concluded in Brenton R. Kusch, supra, that the Director's failure to comply with the mandatory procedure set forth in ORS 656.268(7) does not render the ensuing order void ab initio, but results in an order that may be voided by a party whom the mandatory provision is intended to protect. Here, where claimant refused to waive the mandatory procedure, she thereby voided the voidable Order on Reconsideration, thus invalidating it for purposes of review. See Brenton R. Kusch, supra.

Remand

Claimant submitted as an appendix to her brief a letter from the Workers' Compensation Division, dated February 25, 1992, in which the Department refuses to "reopen the reconsideration process." The insurer relies on the same letter to support its position that we should remand the matter to the Referee for decision on the merits.

On review, we are limited to the record developed at hearing. 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). We consider both parties' requests that we consider this document as a motion for remand for its admission into the record. In this regard, we consider the proffered evidence on review only for purposes of addressing the remand motion.

The document at issue consists of a letter from WCD to the parties in which it notifies them that it refuses to accept jurisdiction over this matter. However, because of the invalidity of the Order on Reconsideration, jurisdiction over this dispute has never left the Department. Soto, supra. Remand to the Referee for the admission of the document will not affect the outcome of the case at hearing, as the authority to proceed with the reconsideration process remains with the Department. Carl R. Alatalo, 44 Van Natta 2097 (1992), on recon 44 Van Natta 2285 (1992). As we stated in Alatalo, supra, we sympathize with the parties' predicament in this case, but if claimant objects to the Department's apparent refusal to take further action, that is for claimant to take up with the Department. Accordingly, the motion to remand is denied.

ORDER

The Referee's order dated February 10, 1992 is affirmed.

November 27, 1992

Cite as 44 Van Natta 2372 (1992)

In the Matter of the Compensation of
MONTY L. LEWIS, Claimant
 WCB Case No. 91-09997
 ORDER ON REVIEW
 Robert Nelson, Claimant Attorney
 Lundeen, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of those portions of Referee Leahy's order that: (1) set aside its denial of claimant's aggravation claim for his low back condition; and (2) found that claimant's proposed surgery was reasonable and necessary. On review, the issues are aggravation and medical services. We affirm in part, vacate in part, and modify in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of the second to last sentence in that section.

CONCLUSIONS OF LAW AND OPINION

Aggravation

The Referee found that claimant had established a compensable aggravation claim for his low back condition. We agree.

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement or award of compensation. ORS 656.273(1). To prove a compensable worsening of his unscheduled low back condition, claimant must show that increased symptoms or a worsened underlying condition resulted in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Further, the worsening must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

In the present case, we find that the last arrangement of compensation was the April 25, 1989 Notice of Closure which amended the medically stationary date of the December 20, 1988 Notice of Closure and affirmed claimant's award of temporary disability benefits without permanent disability benefits.

At the time of the 1989 Notice of Closure, claimant was released to modified work and restricted to lifting no more than 25 pounds. Dr. Pitts diagnosed low back strain and reported that claimant was experiencing occasional back pain after resting in bed for long periods of time or when he bent over to the left. Claimant was able to return to work, and although his symptoms did not resolve, the intensity of the symptoms did not prevent him from working.

However, following his exacerbation in March 1991, Dr. Pitts agreed that claimant's condition had worsened in approximately April 1, 1991, as evidenced by decreased range of motion findings, a compromised gait, vertebral body tenderness and muscle spasm. Dr. Nash, claimant's orthopedic surgeon, eventually diagnosed a ruptured intervertebral disc and took claimant off work indefinitely. In July 1991, surgery was requested for claimant.

We are persuaded that claimant experienced an increase in low back symptoms following the March 1991 exacerbation, rendering him less able to work than at the time of the 1989 Notice of Closure. As claimant was awarded no permanent disability under the Notice of Closure, we find that future exacerbations resulting in a loss of earning capacity were not contemplated. See Louis A. Duchene, 41 Van Natta 2399 (1989). We also find that claimant has proved the worsened condition with medical evidence supported by objective findings. See Georgia Pacific Corporation v. Ferrer, 114 Or App 471 (1992).

We now address the insurer's contention that claimant's off-work incident is the major cause of his worsened condition. The insurer argues that claimant did not have back pain after his compensable injury until he lifted a box at home in either late March or early April 1991. The insurer cites to the reports of the Western Medical Consultants and claimant's treating physician, Dr. Pitts.

We have recently concluded that, although it is claimant's burden of proof to establish a compensable aggravation claim, an insurer which asserts that an off-the-job injury is the cause of claimant's worsened condition has the burden of proving that the off-work incident is the major cause of the worsened condition. See Roger D. Hart, 44 Van Natta 2189 (1992).¹

Here, we agree with the Referee that Dr. Nash has provided the most persuasive opinion regarding causation, and we adopt the Referee's "Opinion" on that issue. Accordingly, we agree with the Referee that the insurer has failed to establish that the off-work incident was the major contributing cause of claimant's worsened condition. We, therefore, affirm the Referee on the issue of aggravation.

Medical services

The Referee found that claimant's proposed surgery was reasonable and necessary. However, we have held that original jurisdiction over such matters rests with the Director. See Kevin S. Keller, 44 Van Natta 225 (1992). Accordingly, we vacate that portion of the Referee's order which found that claimant's low back surgery was reasonable and necessary.

The Referee awarded claimant's counsel an assessed attorney fee of \$2,500 for services concerning the aggravation denial and the medical services issue. Inasmuch as we have vacated the Referee's order with regard to the surgery issue, we modify the Referee's attorney fee award for services at hearing.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing concerning the aggravation issue is \$1,800, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record), the complexity of the issue, and the value of the interest involved.

Attorney Fee/Board Review

Claimant is entitled to an assessed attorney fee for prevailing against the insurer's request for review 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 assessed fee for claimant's counsel's services on review is \$600, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

¹ Member Neidig would direct the parties to her dissent in Roger D. Hart, *supra*.

ORDER

The Referee's order dated January 3, 1992 is vacated in part, modified in part, and affirmed in part. That portion of the Referee's order that found that claimant's proposed surgery was reasonable and necessary is vacated. Claimant's hearing request on that issue is dismissed. In lieu of the Referee's award of a \$2,500 assessed attorney fee, claimant's counsel is awarded an assessed fee of \$1,800, payable by the insurer. The remainder of the Referee's order is affirmed. For services on review concerning the issue of aggravation, claimant's counsel is awarded an assessed attorney fee of \$600, to be paid by the insurer.

November 27, 1992

Cite as 44 Van Natta 2474 (1992)

In the Matter of the Compensation of
CHRISTOPHER P. SCHWARTZMAN, Claimant
WCB Case No. 91-03673
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
David Lillig (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Hooton.

Claimant requests review of those portions of Referee Crumme's order that: (1) dismissed claimant's request for hearing on the SAIF Corporation's de facto denial of medical services; and (2) dismissed claimant's request for a hearing on SAIF's de facto denial of an aggravation claim for a left knee condition. On review, the issue is dismissal. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the following clarification of finding 8.

Dr. Schutte is not licensed to practice medicine in Oregon.

CONCLUSIONS OF LAW AND OPINIONMedical Services

At hearing, claimant raised as an issue SAIF's de facto denial of his claim for medical services. The Referee concluded that the issue was not ripe for adjudication, finding that SAIF had not received a bill for the disputed treatment. In the alternative, the Referee concluded that the medical services issue was not a matter subject to the initial jurisdiction of the Hearings Division, because it involved a dispute about whether the treatment was reasonable and necessary, rather than whether the treatment was related to a compensable condition. We adopt the Referee's alternative holding and affirm. See Stanley Meyers, 43 Van Natta 2643 (1991). With regard to claimant's argument regarding equal protection under the law with regard to treatment by out-of-state doctors, we must rely upon Peacock v. Veneer Services, 113 Or App 732 (1992) in affirming the Referee's order.

Aggravation

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

ORDER

The Referee's order dated October 3, 1991 is affirmed.

In the Matter of the Compensation of
KATHLEEN K. HYDE, Applicant
On Behalf of Christopher Hillary, Deceased
WCB Case No. CV-92004
CRIME VICTIM ORDER
Michael O. Whitty, Assisant Attorney General

Reviewed by Board Members Kinsley and Brazeau.

Kathleen K. Hyde, (hereafter referred to as "applicant"), on behalf of her deceased son, has requested Board review of the Department of Justice's July 24, 1992 Order on Reconsideration. By its order, the Department denied applicant's claim for crime victims' compensation under ORS 147.005 to 147.375. The Department based its denial on insufficient evidence to establish that applicant's son's death was the result of a compensable crime, as required by ORS 147.015(1).

Following our receipt of the request for Board review, applicant was advised that she was entitled to present her case to a hearing officer. To exercise her right to a hearing, applicant was instructed to notify the Board within 15 days from the date the Department mailed her a copy of its record. The Department mailed a copy of its record to applicant on August 26, 1992. Having received no hearing request within the requisite time period, we have conducted our review based solely on the record. OAR 438-82-030(2). The standard for our review under the Act is de novo, based on the entire record. ORS 147.155(5); Jill M. Gabriel, 35 Van Natta 1224, 1226 (1983). Based on our de novo review of the record, we make the following findings and conclusions.

FINDINGS OF FACT

On January 21, 1992, the Department received applicant's January 13, 1992 claim for crime victims' compensation. According to the application, the crime occurred on November 2, 1991, when applicant's 17-year-old son, Christopher Hillary, was fatally shot while deer hunting.

Mr. Hillary had been living with his grandparents in Oregon for several months when the shooting occurred. On the morning of November 2, 1991, Mr. Hillary and his grandfather, Glen Williams, went on a hunting trip. Upon arriving at the hunting area, they parked their vehicle and went in separate directions. Less than five minutes after separating, Mr. Williams heard a shot and then heard Mr. Hillary yell, "Gramps." Mr. Williams heard a second shot a minute or so later, followed by silence. He searched the area but found nothing. He went home and called friends for help in the search. A missing person report was filed with the sheriff's office late that evening.

The next morning, a search team found Mr. Hillary's body lying in a heavily wooded area. He had been fatally shot through the head. His rifle lay on the ground at his feet, along with two spent cartridges and a live round of ammunition.

Based on an analysis of the evidence, the sheriff's office determined that it was unlikely the fatal shot was self-inflicted; therefore, the case was classified as a homicide. However, there was insufficient information from which to determine whether the death was the result of an accident or a deliberate act. The investigation was suspended in April 1992 for lack of further information.

On June 16, 1992, the Department issued its Findings of Fact, Conclusions and Order. Finding insufficient evidence to prove that Mr. Hillary was the victim of a compensable crime, the Department denied the application for compensation pursuant to ORS 147.015(1). Applicant requested reconsideration, contending that there is proof of a compensable crime because Mr. Hillary's death was the result of a reckless act.

On July 24, 1992, the Department issued its Order on Reconsideration. Noting that there is insufficient information from which to determine that Mr. Hillary's death resulted from a criminal act, the Department denied the application for compensation. Applicant requested Board review, contending that Mr. Hillary's death was the result of another person's recklessness.

CONCLUSIONS OF LAW AND OPINION

Under the Act, an applicant is entitled to an award of compensation for medical and funeral expenses incurred as a result of a person's death if the person was a victim of a compensable crime. ORS 147.015(1), 147.025(1). "Compensable crime" means an intentional, knowing or reckless act that results in serious bodily injury or death of another person and which, if committed by a person of full legal capacity, would be punishable as a crime in this state. ORS 147.005(4).

The question here is whether Mr. Hillary's death was the result of an "intentional, knowing or reckless act" which would be punishable as a crime in this state. The sheriff's office has determined only that Mr. Hillary was fatally shot by another unknown person under unknown circumstances; it has not been determined whether the shooting was deliberate or accidental.

Given the lack of information available in this case, there is no basis for finding that the shooting was an intentional or knowing act. Applicant contends that the shooting was, at the very least, a reckless act. However, the Act requires that the reckless act be punishable as a crime in Oregon. ORS 147.005(4). We find no basis for determining that the shooting meets this requirement.

Under the Oregon Penal Code, "recklessly" means that a person is aware of and consciously disregards a substantial and unjustifiable risk that a result will occur. ORS 161.085(9). Thus, criminal recklessness has a specific meaning; it does not include an accidental or, even, negligent act. Compare ORS 161.085(9) and (10). Inasmuch as there is no evidence in this case to determine whether or not the fatal shooting was a reckless act which would be punishable as a crime in Oregon, we conclude that the application for compensation must be denied.

We recognize the emotional and financial trauma that this incident has caused applicant. Yet, to recover crime victims' compensation under the Act, the Legislature has mandated that several specific prerequisites must be satisfied. For the reasons discussed above, one of those prerequisites has not been satisfied in this case. Accordingly, we must deny the application for compensation.

ORDER

The June 16, 1992 Findings of Fact, Conclusions and Order of the Department of Justice, as reconsidered July 24, 1992, is affirmed.

November 17, 1992

Cite as 44 Van Natta 2376 (1992)

In the Matter of the Compensation of
JOHN M. COX, Claimant
WCB Case No. 92-00412
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Westerland and Gunn.

The insurer requests review of Referee Gruber's order that: (1) affirmed an Order on Reconsideration awarding 14 percent (21 degrees) scheduled permanent disability for loss of use or function of claimant's right forearm (wrist); and (2) directed it to pay claimant's scheduled permanent disability award at \$305 per degree. In its brief, the insurer contends that the Referee erred in excluding a report from an independent medical examiner. On review, the issues are evidence, extent of scheduled permanent 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 OPINIONEvidence

On review, the insurer contends that the Referee erred in excluding a report from an independent medical examiner. We conclude that the Referee properly exercised his discretion by refusing to consider the report.

We review the Referee's evidentiary rulings for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991). The disputed report is reviewed only for the purpose of deciding the evidentiary issue before us.

Here, the insurer solicited a report from Dr. Nathan, orthopedist, regarding the medical arbiter's December 4, 1991 impairment findings. Previously, on September 12, 1990, Dr. Nathan had performed an independent medical examination. (Ex. 4). In the March 11, 1992 report at issue, Dr. Nathan questioned the medical arbiter's impairment findings and opined that Nathan's prior examination in September 1990 established that claimant has no impairment regarding his compensable carpal tunnel syndrome.

The insurer argues that ORS 656.268(7) and 656.283(7) simply provide a new cut-off date for determining claimant's impairment, the date of the Order on Reconsideration. Therefore, it argues, because Dr. Nathan's report is not based on information obtained after the Order on Reconsideration but instead discusses the medical arbiter's report and refers back to a previous physical examination, Dr. Nathan's report is admissible as evidence of claimant's impairment at the date of the Order on Reconsideration. We disagree that this evidentiary issue is decided by the fact that, pursuant to the 1990 amendments, evaluation of claimant's disability is now as of the date of the reconsideration order rather than the date of hearing.

Instead, we find that the issue is decided by the fact 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. Conner, 43 Van Natta 2799 (1991).

In effect, the insurer argues that Dr. Nathan's impairment findings should be substituted for those of the medical arbiter. However, Dr. Nathan is neither the attending physician nor the medical arbiter. Therefore, he may not make findings regarding claimant's impairment for the purpose of evaluating claimant's disability. See Agnes C. Rusinovich, 44 Van Natta 1544, 1567 (1992); Easter M. Roach, 44 Van Natta 1740 (1992). Under the circumstances, we conclude that the Referee did not abuse his discretion by excluding Dr. Nathan's March 1992 report.

Extent of Scheduled Permanent Disability

We adopt the Referee's reasoning and conclusions regarding this issue.

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 July 1989 compensable injury. ORS 656.202(2); former ORS 656.214(2).

Attorney Fees on Review

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review insofar as it pertained to the extent of disability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the extent of scheduled permanent disability 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 and statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 22, 1992 is affirmed in part and reversed in part. Those portions of the order that directed the insurer to pay claimant's scheduled permanent disability award at the rate of \$305 per degree and awarded an out-of-compensation attorney fee from this increased compensation are reversed. The remainder of the order is affirmed. For services on review concerning the extent of scheduled permanent disability issue, claimant's attorney is awarded a fee of \$850, to be paid directly to claimant's attorney by the insurer.

November 25, 1992

Cite as 44 Van Natta 2378 (1992)

In the Matter of the Compensation of
LARRY R. HUDNALL, Claimant
 WCB Case No. 91-11748
 ORDER ON REVIEW
 Goldberg & Mechanic, Claimant Attorneys
 Lundeen, et al., Defense Attorneys

Reviewed by Board Members Westerband and Kinsley.

Claimant requests review of Referee Spangler's order that dismissed his request for hearing from an Order on Reconsideration as untimely. On review, the issue is dismissal.

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

The Workers' Compensation Board received claimant's August 28, 1991 request for hearing on August 29, 1991.

Inasmuch as claimant's hearing request was filed before the issuance of the Director's Order on Reconsideration, the Referee reasoned that the request was premature and did not bestow jurisdiction on the Hearings Division to consider the subsequently issued Order on Reconsideration. We agree. See Barr v. EBI, 88 Or App 132 (1987); Naught v. Gamble, Inc., 87 Or App 145 (1987); Lorna D. Hilderbrand, 43 Van Natta 2721 (1991).

Noting that an Order on Reconsideration did not issue within its statutory deadline, claimant contends that he was entitled to seek a hearing because of the Director's inaction. We acknowledge that the Director apparently failed to perform his statutory obligations within the requisite time period. Nevertheless, the statutes applicable to this case do not restrict the Director's authority to act after expiration of the required time period nor is there a clear statutory indication that the Director's failure to timely issue an Order on Reconsideration permits a party to seek a hearing prior to issuance of that order.

Although the failure to comply with a statute may subject the Director to mandamus, it would not deprive the Director of the power to act. See Lyday v. Liberty Northwest Insurance Corporation, 115 Or App 668 (1992). (Referee's failure to issue an order within 30-day statutory time period does not deprive referee of power to act). Since the Hearings Division's review authority under ORS 656.268(6)(b) is expressly contingent on the issuance of a reconsideration order and because claimant requested a hearing prior to the issuance of that order and, following the eventual issuance of that

order, did not request a hearing within the requisite 180 day appeal period, we agree with the Referee that the Hearings Division was without authority to consider claimant's appeal.

ORDER

The Referee's order dated January 6, 1992 is affirmed.

November 30, 1992

Cite as 44 Van Natta 2379 (1992)

In the Matter of the Compensation of
ROBERT CRUZ, Claimant
WCB Case No. 92-00694
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

The insurer requests review of Referee Mills' order that increased claimant's unscheduled permanent disability award from 18 percent (57.6 degrees), as awarded by Order on Reconsideration, to 28 percent (89.6 degrees) unscheduled permanent disability for his 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

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

On review, the insurer contends that the Referee erred by relying on claimant's testimony, rather than the evidence of the doctor's release, to establish that claimant had not returned to regular work. We disagree.

We have previously held that, notwithstanding a doctor's release to regular work, a claimant's credible, un rebutted testimony may establish that he actually performed modified work upon his return to work after the injury. See Beverly J. Ramey, 43 Van Natta 2335 (1991); Edward L. Sullivan, 43 Van Natta 932 (1991). Such testimony may be sufficient proof that, for purposes of an adaptability value, a claimant has returned to modified work, rather than his usual and customary work. Ramey, supra.

Accordingly, in the present case we agree with the Referee that claimant has established that he returned to modified, rather than regular work. We, therefore, affirm the Referee on the issue of extent of unscheduled permanent disability.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for a reduction of his award of unscheduled permanent disability. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the issue of extent is \$400, 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 statement of services), the complexity of the issue and the value of the interest involved.

ORDER

The Referee's order dated April 17, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of \$400, to be paid by the insurer directly to claimant's attorney.

In the Matter of the Compensation of
TINA R. FLANSBERG, Claimant
WCB Case Nos. 90-22505, 90-17315 & 90-15708
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Kevin Mannix, PC, Defense Attorneys
Beers, et al, Defense Attorneys
Garrett, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Brazeau.

Liberty Northwest Insurance Corporation requests review of those portions of Referee Black's order that: (1) found claimant's bilateral carpal tunnel syndrome condition to be compensable; and (2) found Liberty Northwest and Safeco Insurance Company to be jointly responsible for the condition. Safeco requests review of that portion of the order that found claimant's condition to be compensable. On review, the issues are compensability and responsibility. We modify.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the Referee's conclusions and opinion concerning this issue, with the following supplementation.

Based on Dr. Button's opinion and claimant's testimony, we find that the combination of claimant's work activities with both employers was the major contributing cause of her bilateral carpal tunnel syndrome condition.

Responsibility

The Referee apparently applied the last injurious exposure rule to find that the two employers, Taco Bell and Bason, are concurrently responsible for claimant's bilateral carpal tunnel syndrome condition. We do not agree that the last injurious exposure rule applies here and, therefore, substitute the following analysis.

In Colwell v. Trotman, 47 Or App 855 (1980), the Court of Appeals stated that the last injurious exposure rule was judicially created to place full responsibility for an occupational disease on the last of successive employers in whose service a worker was exposed to conditions contributing to the disease. The court explained that the adoption of the rule was necessary to relieve workers of the potentially impossible burden of proving the date of actual contraction of an occupational disease. Id. at 858 (citing Mathis v. SAIF, 10 Or App 139 (1972)). The court specifically expressed concern that a worker who had been employed by successive employers and had developed a disease due to work exposure, might file a claim against the wrong employer and later be barred by the filing limitations statute from filing a claim against the correct employer. Id. See also Inkley v. Forest Fiber Products Co., 288 Or 337, 343 (1980).

The Colwell court stated, however, that the aforementioned rationale does not support application of the last injurious exposure rule to concurrent employment exposures, i.e., where the worker was exposed to conditions which contributed to an occupational disease in two separate, but simultaneous, employments. Id. The court noted, in particular, that a worker is unlikely to encounter filing limitation problems of the kind likely to arise in successive employment situations. Id. Therefore, the court declined to apply the rule in a concurrent employment situation.

In this case, claimant's employments were not purely concurrent. Claimant began working part time for Taco Bell in January 1990 and for Bason in February 1990. She last worked for Bason on July 11, 1990, but continued to work for Taco Bell until October 1990. Thus, unlike the worker in Colwell, claimant's employments were not exactly simultaneous.

Nonetheless, we find that the policy rationale cited by the Colwell court for not applying the last injurious exposure rule to concurrent employment situations applies with equal force to this case. Our reasoning stems from the fact that claimant began experiencing symptoms while she was still concurrently employed. Although claimant did not seek treatment for her condition until July 16, 1990, she was experiencing symptoms during the previous week or two. (Ex. 3-1; Tr. 31). Indeed, she completed and signed the 801 claim form for her condition on July 10, 1990, though it was not actually filed until July 16, 1990. (Ex. 2).

Thus, this case is unlike the typical successive employment situation, where the worker has developed a disease as a result of work conditions in one or more successive employments, but does not manifest symptoms of the disease until the last employment. In that situation, as the Colwell court reasoned, a worker could file a claim against the last employer, lose in litigation on the merits of the claim, and then be barred by the filing limitations statute from filing a claim against the earlier employer.¹

Here, on the other hand, claimant manifested symptoms while concurrently employed. Under the circumstances of this case, therefore, a worker is unlikely to experience the filing limitation problems that concerned the court in Colwell. For that reason, we decline to apply the last injurious exposure rule in this case. See Mary J. Joseph-Duby, 44 Van Natta 2272 (1992).

On review, each insurer contends that responsibility for this claim should be assigned to the insurer on the risk on the "date of disability." However, the "date of disability" in the occupational disease context is legally significant only insofar as it is used to assign responsibility under the last injurious exposure rule. See Bracke v. Baza'r, 293 Or 239, 247 (1982); Inkley v. Forest Fiber Products Co., 288 Or at 342-43. Here, on the other hand, we do not apply the last injurious exposure rule. Accordingly, we decline to assign or allocate responsibility for this claim based on the date of disability.

Rather, we analyze this case on the basis of actual causation. As we found above, the record establishes that the combination of both employments was the major contributing cause of claimant's condition, which resulted in disability and the need for treatment. Claimant was under contract with both employers and under each employer's separate control. She performed services separately for each employer. The services she performed for each employer were unrelated to services for the other. Therefore, we find that this case presents a "dual employment" situation. See Mission Insurance Co. v. Miller, 73 Or App 159, 163 (1985) (citing 1C Larson, Workmen's Compensation Law, § 48.40 (1982)); David R. Abbott, 44 Van Natta 132 (1992); Dallas H. Greenslitt, 40 Van Natta 1038 (1988).

In a dual employment case, the employers may be held responsible for compensation separately or jointly, depending on the severability of the worker's activities at the time of "injury." Mission Insurance Co. v. Miller, *supra*. This case concerns an occupational disease, not an injury. The date or time of contraction of the disease cannot be established with the same degree of certainty that the time of an injury can be established. We have found, however, that claimant's condition resulted from the combination of work activities performed for both employers. Under these circumstances, there is no rational basis for assigning responsibility solely to either employer. Rather, we conclude that the employers must be held jointly responsible for claimant's condition and any resulting disability and need for treatment.

Finally, we note that Taco Bell was covered separately by two insurers during the period of claimant's employment prior to the onset of her condition and the need for treatment. Connecticut Indemnity provided coverage when claimant began her employment until June 30, 1990. Coverage then transferred to Safeco on July 1, 1990 and continued through the end of claimant's employment. As an insurer on the risk during a period of claimant's employment with Taco Bell which contributed to

¹ We note that the current law provides safeguards designed to prevent the filing limitation problems discussed by the Colwell court. For example, ORS 656.308(2) requires that an insurer/employer which intends to disclaim responsibility for a disease claim on the basis of an exposure with another insurer/employer must notify the worker as to its position within 30 days of actual knowledge of the claim. The worker is then allowed 60 days in which to file a claim against the other insurer/employer. Notwithstanding these recent developments, however, we remain persuaded that Colwell controls the outcome of this case.

claimant's condition, Connecticut Indemnity must bear a portion of the responsibility for claimant's condition, along with Safeco and Liberty Northwest. All three insurers are directed to petition the Director pursuant to OAR 436-60-195(1) for the apportionment of compensation due as a result of claimant's condition. See Loretta J. O'Rourke, 44 Van Natta 2264 (1992). The Referee's attorney fee award of \$3,000 shall be paid by the three responsible insurers, with each insurer paying a one-third share.

Claimant is entitled to an assessed attorney fee for prevailing over Liberty Northwest's request and Safeco's cross-request for review on the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue is \$700, one half to be paid by Liberty Northwest and the other half to be paid by Safeco. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 6, 1992 is modified in part and affirmed in part. The denials by Safeco Insurance Company, Liberty Northwest Insurance Corporation and Connecticut Indemnity Company are set aside, and all three insurers are jointly responsible for claimant's bilateral carpal tunnel syndrome condition. The claims for that condition are remanded to the insurers for processing according to law, including the petitioning of the Director for apportionment. The Referee's attorney fee award of \$3,000 shall be paid by the three responsible insurers, with each insurer paying a one-third share. Claimant's attorney is awarded \$700 for services on Board review, to be paid in equal shares by Liberty Northwest and Safeco. The remainder of the order is affirmed.

November 30, 1992

Cite as 44 Van Natta 2382 (1992)

In the Matter of the Compensation of
KIMBERLYN GALAN, Claimant
 WCB Case No. 91-11848
 ORDER ON REVIEW
 Royce, et al., Claimant Attorneys
 Mitchell, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Westerland.

The self-insured employer requests review of Referee Spangler's order that set aside its denial of claimant's occupational disease claim for an asthma condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact." We do not adopt the Referee's "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant had proven a compensable occupational disease. We disagree.

Claimant has the burden of proving, by medical evidence supported by objective findings, that her employment conditions were the major contributing cause of a worsening of her preexisting asthma condition. ORS 656.802(2). Claimant must establish a pathological worsening of her underlying condition as opposed to a mere worsening of symptoms. Weller v. Union Carbide, 288 Or 27 (1979); Kenneth L. Orr, 43 Van Natta 1432 (1991). Here, there is insufficient medical evidence from which to find that claimant's underlying condition was pathologically worsened.

The record contains several expert medical opinions. Claimant's treating physician, Dr. Green, a specialist in allergies and environmental medicine, opined that new carpeting at work caused a "very

significant aggravation" of claimant's asthma. Dr. Morton, a specialist in environmental medicine, saw claimant at the recommendation of Dr. Green. He also opined that new carpets at work had caused a severe aggravation of claimant's asthma. Dr. Morton further stated that although claimant has had asthma since 1984, she was improving until new carpets at work "aggravated her symptoms and have made it impossible for her to return to work." Dr. Morton diagnosed occupational aggravation of pre-existing asthma.

Claimant was also seen in an independent evaluation by Dr. Montanaro, who specializes in allergy, immunology and rheumatology. He opined that the chemicals in the carpets to which claimant was exposed caused a symptomatic aggravation of her condition. However, he felt that the workplace exposures did not worsen claimant's longstanding underlying condition. Dr. O'Halloren, a specialist in allergy and immunology, and Dr. Blair, a pulmonary specialist, both concurred with Dr. Montanaro. Drs. Blair and O'Halloren have each treated claimant in the past for her asthma condition and, therefore, were in a good position to evaluate any change in claimant's underlying condition.

None of the medical opinions indicate that claimant's underlying asthma condition was pathologically worsened by claimant's work exposure. Drs. Green and Morton merely indicate that the work exposure "aggravated" claimant's asthma. It is impossible to determine from the record whether Dr. Green and Dr. Morton felt that this aggravation represented a worsening of the underlying asthma condition or merely worsened symptoms. Moreover, Montanaro, the only physician who specifically addressed this question, concluded that the underlying condition had not worsened due to the industrial exposure.

We recognize that a May 1, 1991 emergency room report indicated that during the most severe exacerbation, claimant was "cyanotic with abnormal arterial blood gasses." However, absent expert medical evidence that the report establishes a worsening of the underlying condition, we cannot make such a finding. Accordingly, on this record we are unable to find that claimant's work exposure pathologically worsened her preexisting asthma condition.

Finally, claimant contends that her symptoms are the disease of asthma, and that therefore, she established a worsened disease by proving worsened symptoms. Once again, however, there is no medical evidence in the record which would support a conclusion that claimant's symptoms are the disease. Absent medical evidence, we are unable to make such a finding.

ORDER

The Referee's order dated December 18, 1991, as reconsidered on January 27, 1992, is reversed. The Referee's \$4,687.50 attorney fee award is also reversed.

November 30, 1992

Cite as 44 Van Natta 2383 (1992)

In the Matter of the Compensation of
ANTHONY G. MERRILL, Claimant
WCB Case No. 91-07428
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Westerland and Kinsley.

The self-insured employer requests review of that portion of Referee Peterson's order that set aside its denial of claimant's claim for vertebral osteomyelitis, staphylococcal bacteremia and staphylococcal glomerulitis. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

In December 1985, claimant injured his back at work. He sought treatment from Dr. Hazel, who diagnosed a herniated disc at L4-5 and provided conservative treatment. The employer accepted that

claim, which was closed by a July 2, 1990 Determination Order with an award of benefits for 10 percent unscheduled permanent partial disability (PPD).

Claimant continued to experience low back and leg pain and returned to Dr. Hazel for additional treatment. On July 10, 1987, Dr. Hazel performed an L4-5 hemilaminotomy and L4-5 discectomy on the right. When claimant failed to improve, Dr. Hazel performed a second surgery consisting of a hemifacetectomy, partial laminectomy and discectomy at L4-5 on the left. The claim was reclosed by a July 27, 1989 Determination Order, which awarded a total of benefits for 38 percent unscheduled PPD.

Despite the surgeries, claimant continued to experience persistent pain. In January 1991, he noticed that his low back and leg symptoms became much more severe and, by February 2, 1991, he was unable to walk and had developed a fever. He sought treatment from Dr. Bahr, general practitioner, who misdiagnosed claimant's condition as a urinary tract infection. When claimant's condition failed to improve, he was hospitalized on February 7, 1991, and Dr. Bahr referred him to Dr. Connor, a specialist in infectious diseases. Dr. Connor took an extensive history from claimant and his wife and discovered that claimant experienced frequent acne and ingrown hairs. Based on his examination and history, Dr. Connor diagnosed a staphylococcal infection of claimant's kidneys and vertebral lesions.

On March 21, 1991, claimant filed a claim for vertebral osteomyelitis, staphylococcal bacteremia and staphylococcal glomerulitis. On May 29, 1991, the employer denied the claim, asserting that the conditions were unrelated to claimant's work. Claimant subsequently requested a hearing, which was convened on March 19, 1992.

CONCLUSIONS OF LAW AND OPINION

Claimant seeks compensation for treatment and disability for his current condition diagnosed as vertebral osteomyelitis, staphylococcal bacteremia and staphylococcal glomerulitis. The Referee found that the condition was compensable on the basis that it was related, in major part, to claimant's 1985 low back injury. We disagree and reverse.

At the outset, we note that claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Thus, contrary to claimant's contention, 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).

Claimant is asserting the compensability of his current condition as a consequence of his 1985 compensable low back injury and resultant low back surgeries. Under these circumstances, claimant has the burden to prove, by a preponderance of the evidence, 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 current 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).

Evidence from four medical experts was presented. Claimant relies on the opinions of his two treating physicians, Dr. Bahr and Dr. Hazel. Dr. Bahr opined that claimant's current condition and need for medical treatment is primarily related to his back surgeries following his compensable injury in 1985. Dr. Hazel agreed, explaining that claimant's L4-5 disc space was altered as a result of the two surgeries, "rendering it more vulnerable to capturing this shower of bacteria that subsequently grew and developed [in] what amounts to an abscess in the disc space." (Ex. 51). Both physicians believe that claimant contracted the staphylococcal bacterium during his back surgeries.

The employer relies on Dr. Connor and Dr. Bryant. Dr. Connor, who specializes in infectious disease processes, also concluded that claimant's current condition was caused by staphylococcus bacterium, but opined that it was extremely unlikely that the bacterium was caused by claimant's prior back surgery. Had that been the case, Dr. Connor believed that the infection would have erupted within a few days or weeks from the date of the April 1988 surgery. Dr. Connor concluded that the bacterium was most likely caused by a skin infection, and that the surgical site merely proved a more fertile ground for seeding by the bacterium.

Dr. Bryant, the Director of the Infectious Disease Division at the Oregon Health Sciences University, testified that claimant's surgery probably rendered claimant more vulnerable to disc infection, but that, in his opinion, the surgery was not the major cause of claimant's current condition. He explained that vertebral infections occur as a result of disc surgery in only one to three percent of the cases, and that the vast majority of those cases occur within a month of surgery. He agreed that a staph infection may lay dormant, but added that long term dormancy is extraordinarily rare and that the longest period of dormancy ever recorded was less than five months. Given claimant's history of acne and ingrown hairs and the length of time between the surgery and the appearance of the infection, he opined that the most likely explanation was that claimant's back was seeded by some unknown skin source.

We find the opinions of Dr. Connor and Dr. Bryant more persuasive. When medical experts disagree, we rely on the opinions that are well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). Only Dr. Connor's and Dr. Bryant's opinions meet those criteria. Neither Dr. Bahr nor Dr. Hazel is a specialist in infectious diseases. In fact, Dr. Hazel admitted his lack of understanding of claimant's condition, concluding that it was a "full blown mystery." (Ex. 51-2). Dr. Bahr also acknowledged that medical experts are unable to identify the cause of many disc infections and that it was "unlikely" for a staph infection to lay dormant for more than a year after surgery. (Ex. 55-51).

After our review of the record, we find that claimant has failed to prove by a preponderance of the evidence that his current condition and need for treatment was caused in major part by his 1985 compensable injury of resultant low back surgeries. Accordingly, we conclude that claimant has failed to establish the compensability of the consequential condition and uphold the employer's denial. ORS 656.005(7)(a)(A).

ORDER

The Referee's order dated March 30, 1992 is reversed. The employer's denial of claimant's current condition is reinstated and upheld. The Referee's assessed attorney fee of \$2,500 for services rendered in overturning the denial is reversed.

November 30, 1992

Cite as 44 Van Natta 2385 (1992)

In the Matter of the Compensation of
BEN G. SANTOS, Claimant
WCB Case Nos. 91-08869 & 91-02704
ORDER ON RECONSIDERATION
Schneider & DeNorch, Claimant Attorneys
Roberts, et al., Defense Attorneys
James Dodge (Saif), Defense Attorney

The SAIF Corporation, as insurer for Press Specialties (SAIF/Press), requests reconsideration of those portions of our October 30, 1992 Order on Review that: (1) awarded claimant interim compensation from April 1, 1991 through August 27, 1991, payable by SAIF/Press; (2) awarded an assessed attorney fee for SAIF/Press' untimely denial and failure to pay interim compensation; and (3) awarded a penalty based on the amounts then due at hearing, including medical services, for SAIF/Press' unreasonable denial of compensability. SAIF/Press contends that we erred in making those awards. We disagree.

Regarding the award of interim compensation, SAIF/Press argues that we improperly imputed the conduct of the claims adjuster for SAIF, as insurer for Caryall Transport (SAIF/Caryall), to the claims adjuster for SAIF/Press. SAIF/Press' argument was adequately addressed in our initial Order on Review; we have nothing further to add to our prior order.

SAIF/Press also argues that claimant is not entitled to an assessed attorney fee for its untimely denial in addition to the penalty awarded for its unreasonable denial of compensability. Our original order adequately addressed that argument. However, to clarify the fact that we based the separate penalty and assessed attorney fee award on two separate and distinct acts of unreasonable conduct, we replace the last sentence of the eighth paragraph of our section entitled "Untimely Denial" with the following sentence. Thus, claimant is entitled to an attorney fee based on SAIF/Press' untimely denial

and its failure to pay interim compensation, as well as a separate penalty based on SAIF/Press' unreasonable denial of compensability. (The footnote referenced in the original sentence remains unchanged).

SAIF/Press relies on our decision in Robert A. Brooks, Jr., 44 Van Natta 1105 (1992), in support of its argument that claimant is not entitled to an assessed attorney fee for its untimely denial in addition to the penalty awarded for its unreasonable denial of compensability. In Brooks, supra, we found that the insurer's conduct constituted two separate claims processing violations: (1) its denial was unreasonable; and (2) its failure to pay interim compensation constituted an unreasonable resistance to the payment of compensation. For these separate violations, we awarded separate penalties totalling 25 percent of the amount due at hearing, including medical services. However, we declined to award a separate assessed attorney fee for the insurer's unreasonable denial in addition to the portion of the total 25 percent awarded as a penalty.

Here, we have awarded claimant a penalty of 25 percent of the amount due at hearing, including medical services, for SAIF/Press' unreasonable denial of compensability. We have also awarded an assessed fee for the separate processing violations of untimely denial and failure to pay interim compensation. As restated above, we adhere to our decision that these are separate and distinct processing violations which support a separate assessed attorney fee. In reaching this conclusion, we observe that perhaps Brooks, supra was wrongly decided. Indeed, if that case were before us at the present time, instead of splitting a penalty between the two separate violations, we might very well award a penalty and a separate assessed attorney fee for the separate infractions.

Finally, SAIF/Press argues that the amounts upon which we based the penalty for its unreasonable denial of compensation may not include unpaid medical services. It cites Meier & Frank Co. v. Smith-Sanders, 115 Or App 159 (1992), which in turn relies on Eastmoreland Hospital v. Reeves, 94 Or App 698 (1989), in support of its argument.

We relied on our decisions in Harold R. Borron, 44 Van Natta 1579 (1992), and Kim S. Jeffries, 44 Van Natta 419 (1992), in concluding that the penalty for SAIF/Press' unreasonable denial of compensability should be based on all amounts due at hearing, including medical services. In Jeffries, supra, we distinguished Eastmoreland Hospital v. Reeves, supra, on the basis that it did not deal with an unreasonable denial. The same distinction applies to Meier & Frank Co. v. Smith-Sanders, supra. That is, neither Eastmoreland nor Meier & Frank Co. involves a compensable claim that had been unreasonably denied with the claim being ultimately found compensable at hearing.

Where the question is the reasonableness of the denial, the penalty is assessed as of the time of the hearing. See Wacker Siltronic Corp v. Satcher, 91 Or App 654, 658 (1988). When a penalty for an unreasonable denial is assessed at the time of the hearing, the denial has been set aside and all expenses incurred by claimant for medical services and all time loss become amounts then due. Claimant, as of the time of the order, has become substantively entitled to every benefit the Act allows without regard for the date upon which medical services were rendered or time loss incurred. Kim S. Jeffries, supra at 826. In this way, the penalty bears a reasonable relationship to the wrong done. Wacker Siltronic Corp v. Satcher, supra. Thus, the basis of a penalty for an unreasonable denial encompasses all amounts then due at the date of the hearing, including medical services. Kim S. Jeffries, supra.

Here, SAIF/Press unreasonably denied compensability of claimant's claim, and the claim was found compensable at hearing. Therefore, the basis of the penalty for the unreasonable denial is the amount then due at hearing, including medical services. Harold R. Borron, supra, and Kim S. Jeffries, supra.

Accordingly, we withdraw our October 30, 1992 order. On reconsideration, as supplemented herein, we adhere to our October 30, 1992 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
STEVEN J. SPAUR, Claimant
WCB Case No. 91-14894
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Julie K. Bolt (Saif), Defense Attorney
Reviewed by Board Members Moller and Brazeau.

The SAIF Corporation, on behalf of the noncomplying employer, requests review of Referee Gruber's order which: (1) awarded additional interim compensation; and (2) assessed a penalty for SAIF's failure to pay that additional interim compensation. On review, the issues are interim compensation and penalties and attorney fees. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

SAIF, on behalf of the noncomplying employer, paid claimant interim compensation from October 2, 1991, the date the Department referred the claim to SAIF, to October 15, 1991, the date of claim denial. The Referee found that claimant was entitled to additional interim compensation benefits beginning July 16, 1991, the date a prior carrier had stopped providing compensation. We disagree.

"Interim compensation" is temporary disability payments made between the employer's notice of the injury and the acceptance or denial of the claim. Bono v. SAIF, 298 Or 405, 407 n. 1 (1984). A claimant's entitlement to interim compensation is triggered by the carrier's notice or knowledge of the claim. See ORS 656.262(4)(a); Stone v. SAIF, 57 Or App 808, 812 (1982). When the employer is noncomplying, the first payment must be made within 14 days of the claim's referral to SAIF by the director. ORS 656.054(1); Joseph E. Dabacon, 43 Van Natta 1962, 1963 (1991).

Subsequent to the Referee's order, we addressed the proper period of time that must be covered by the first installment of compensation by SAIF when it has been referred a claim by the Department under ORS 656.054. In Larry K. Melton, 44 Van Natta 1145 (1992), we found that it is SAIF's first notice of claimant's inability to work due to an injury, rather than the date of disability, which triggers claimant's entitlement to interim compensation. In other words, if the claim is compensable, temporary disability compensation (as opposed to interim compensation) is due from the date of disability. Sandra L. Berkey, 41 Van Natta 944 (1989). If the claim is not compensable, interim compensation runs only from the date of SAIF's notice of the claim. Id.

Here, because claimant worked for a noncomplying employer, the director referred his claim to SAIF for processing on October 2, 1991. SAIF began paying claimant interim compensation benefits on October 2, 1991. It stopped such payments on October 15, 1991, the date of its denial. At the time of the hearing in this case, claimant's request for hearing from this denial was pending.

Given the fact that claimant's claim was in denied status at the time of hearing, any time loss compensation due claimant is in the form of interim compensation. Therefore, we conclude that claimant's entitlement to interim compensation could not run before the date of SAIF's notice. Larry K. Melton, supra. Accordingly, we reverse that portion of the Referee's order that found claimant entitled to interim compensation benefits beginning July 16, 1991. The Referee's attorney fee award of 25 percent of the increased compensation created by the award is also reversed.

In light of our conclusion that claimant was not entitled to interim compensation beginning July 16, 1991, it follows that SAIF's failure to provide such payments was not unreasonable. Therefore, we reverse the Referee's penalty assessment.

ORDER

The Referee's order dated April 17, 1992 is reversed.

In the Matter of the Compensation of
JOSEPH E. STEELE, Claimant
WCB Case Nos. 91-06159 & 91-06160
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Schwabe, et al., Defense Attorneys
Lester Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of that portion of Referee Baker's order that awarded claimant a \$2,000 assessed attorney fee for prevailing against SAIF's denial insofar as it pertained to "arm numbness." Claimant cross-requests review of those portions of the Referee's order that: (1) upheld SAIF's denial of his current condition of arm numbness diagnosed as bilateral thoracic outlet syndrome; and (2) upheld Scott Wetzel's denial of the same condition. On review, the issues are compensability, responsibility and attorney fees. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Scope of SAIF's Denial

The Referee found that although claimant had not established that his employment has caused or worsened a thoracic outlet syndrome, SAIF's denial of claimant's current condition of "arm numbness" was overly broad in that it encompassed SAIF's accepted conditions as well as the diagnosed thoracic outlet syndrome. On this basis, the Referee awarded a \$2,000 assessed attorney fee to claimant for overturning the portion of the denial which went beyond a denial of thoracic outlet syndrome.

On review, SAIF contends that the \$2,000 attorney fee award was inappropriate because its denial was limited to thoracic outlet syndrome and was not intended to be a denial of claimant's current condition of arm numbness.

The pertinent portion of SAIF's denial provides: "Information in your file indicates that your current condition of arm numbness, diagnosed as thoracic outlet syndrome, is unrelated to your cervical and low back strains. Therefore, we must deny your request to reopen this claim." Based on the language of the denial, we find that SAIF's denial was a denial of claimant's current condition rather than a partial denial of the specific condition of thoracic outlet syndrome.

At hearing, the Referee stated the issue before him by stating: "Okay. And the record should be clear since claims are not about medical diagnoses. The claim is really for [claimant's] condition, which has been diagnosed most often as thoracic outlet syndrome. Is that correct, Mr. Garrow?" (Tr. 9). Claimant's attorney agreed to the Referee's characterization of the issue before him and neither insurer objected.

We find no evidence in the record that SAIF orally amended its denial at hearing to relate only to the specific condition of thoracic outlet syndrome. Accordingly, the issue before the Referee was, and consequently the issue before the Board is, the compensability of claimant's current arm numbness condition, however it is diagnosed, and responsibility for that condition.

Compensability

Claimant has a history of multiple surgeries which includes an anterior cervical discectomy and fusion at C6-7, a lumbar laminectomy and discectomy at the L5-S1 level, a cervical discectomy and fusion at C5-6, a posterolateral fusion of L5 to the sacrum with bilateral foraminotomy and decompression of the L4-5 interspace, bilateral carpal tunnel releases, and a right rotator cuff repair. In light of his complicated medical history, we find that the causation of claimant's arm numbness is of

sufficient complexity that we cannot decide it without expert medical testimony. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985). Here, although the medical experts disagree concerning the appropriate diagnosis for claimant's arm numbness, they are in agreement that the arm numbness symptoms are related to claimant's employment.

Claimant's attending physician, Dr. Newby, has diagnosed claimant's condition as thoracic outlet syndrome since approximately May 1989. Newby has opined that claimant's condition is related to his work for SAIF's insured.

Dr. Taylor and Dr. Mertens saw claimant in an independent medical examination on behalf of SAIF. They diagnosed claimant's current condition as bilateral tennis elbow and residual right C6 radiculopathy. In addition, Dr. Taylor opined: "I believe that [claimant's] job exposure between April 29, 1985 and August 5, 1987, which was an accepted claim for cervical and low back strain, contributed to his current symptoms." Based on this statement, we conclude that Dr. Taylor was referring to claimant's accepted occupational disease claim for a cervical and low back condition with SAIF. This claim had an onset date of April 29, 1985 and was first closed by Determination Order on August 5, 1987.

Thus, although their diagnoses differ, all of the medical experts relate claimant's current condition to his work exposures. There is no contrary medical evidence. Accordingly, claimant has established compensability of his current arm numbness condition variously diagnosed as thoracic outlet syndrome or cervical radiculopathy and bilateral tennis elbow. Having found claimant's current condition compensable, we determine which carrier is responsible.

Responsibility

Under ORS 656.308(1), in cases where an accepted injury is followed by an increase in disability during employment with a later carrier, responsibility rests with the original carrier unless the claimant sustains an actual, independent compensable injury during the subsequent work exposure. Ricardo Vasquez, 43 Van Natta 1678 (1991). Thus, SAIF, as the last insurer against whom claimant had an accepted occupational disease, remains presumptively responsible. Thus, in order to avoid responsibility, SAIF has the burden of establishing that claimant sustained a new compensable injury involving the same condition while working for Scott Wetzel/Seaswirl in October 1990.

In order to prove a "new compensable injury," SAIF must show that the 1990 fall at Scott Wetzel's insured was a material contributing cause of disability or need for treatment. Mark N. Wiedle, 43 Van Natta 855 (1991). The new injury must be established by medical evidence supported by objective findings. Id.

Dr. Newby opined that the October 1990 incident, in which claimant fell on his shoulders, neck and head, caused increasing symptoms but was not the major cause of claimant's current condition and need for medical treatment. At his deposition, Dr. Newby explained his opinion regarding the contribution of the October 1990 fall:

" * * * If I could explain, I think in October when [claimant] had an accident, he needed some work up and evaluation to see if any more damage or stuff had been done. Nothing turned out on that. So at that point, when I wrote that letter, I think you know he's back to about where he's always been: nagging neck pain, some back pain, some arm pain.

So, the accident in October is not playing a whole lot of a role in where he's at right now but that accident did cause a need for some temporary evaluations * * *."

Dr. Newby's opinion suggests that claimant did not suffer a new injury, but rather, had increasing symptoms due to his prior accepted claim. See Taylor v. Multnomah School Dist. No. 1, 109 Or App 499 (1991). We further note that Dr. Newby had diagnosed claimant's condition as thoracic outlet syndrome prior to the October 1990 injury. As previously noted, Dr. Taylor believed that the accepted claim with SAIF had contributed to claimant's current symptoms. Based on the aforementioned medical evidence, we find that claimant did not sustain a new compensable injury or

disease at Scott Wetzel/Seaswirl. See Gerald K. Mael, 44 Van Natta 1481 (1992). Accordingly, SAIF remains responsible for claimant's current condition.

We have concluded that claimant's current condition of arm numbness is compensable and that SAIF is the responsible insurer. However, by our decision, we have not determined the appropriateness of the surgery that Dr. Newby proposes as treatment for the compensable condition (diagnosed as thoracic outlet syndrome). If SAIF, as the responsible insurer, disputes that the surgery proposed by Drs. Newby and Goldsmith is reasonable and necessary to treat the compensable condition, it should request Director review of the treatment under ORS 656.327(1). This action is necessary because the Board and its Hearings Division no longer have original jurisdiction over such disputes. See Kevin S. Keller, 44 Van Natta 225 (1992); Stanley Meyers, 43 Van Natta 2463 (1991).

Attorney Fees

Because we have set aside SAIF's denial in its entirety, we award claimant 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 for prevailing against SAIF's denial in its entirety is \$2,700, to be paid by the SAIF Corporation. This attorney fee award is in lieu of the Referee's award of \$2,000. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated January 9, 1992 is modified. SAIF's denial is set aside in its entirety and the claim remanded to SAIF for further processing according to law. In lieu of the Referee's attorney fee award of \$2,000, claimant's attorney is awarded \$2,700 for services at hearing and on review, payable by the SAIF Corporation.

November 30, 1992

Cite as 44 Van Natta 2390 (1992)

In the Matter of the Compensation of
JUDY K. SUITOR, Claimant
 WCB Case Nos. 91-11707 & 90-21870
 ORDER ON REVIEW
 Karen M. Werner, Claimant Attorney
 VavRosky, et al., Defense Attorneys
 Schwabe, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

Continental Loss Adjusting Services (CLA) requests review of those portions of Referee Myers' order that: (1) set aside its denial of responsibility for claimant's "new injury" claim for a low back condition; and (2) upheld CIGNA Insurance Companies' denial of responsibility for claimant's aggravation claim for the same condition. On review, the issue is responsibility.

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

On review, CLA argues that CIGNA should be held responsible for claimant's low back condition because it refused to provide claimant palliative care thereby making her susceptible to the March 1991 reinjury. CLA also notes that Dr. McIntyre, the attending physician, opined that claimant's condition in March 1991 "probably represented an aggravation of longstanding disability from chronic overuse syndrome." (See Ex. 22A-1).

Even assuming that CIGNA's refusal to provide palliative care made claimant susceptible to reinjury, we are persuaded that responsibility for claimant's low back condition must shift to CLA in accordance with ORS 656.308(1). Under that statute, responsibility for a compensable condition shifts to a subsequent insurer when claimant sustains a new compensable injury involving the same condition

with that insurer. See Ricardo Vasquez, 43 Van Natta 1678 (1992). A new compensable injury is established by proof that work activities while the subsequent insurer was on the risk were a material contributing cause of claimant's subsequent disability and need for treatment. ORS 656.005(7)(a); Mark N. Weidle, 43 Van Natta 855 (1991). The injury must also be established by medical evidence supported by objective findings. Id.

We find that claimant's work activities on March 20, 1991, while CLA was on the risk, were a material contributing cause of her subsequent disability and need for treatment. Dr. McIntyre, after rendering the aforementioned opinion describing claimant's condition as an "aggravation," concurred that the March 20, 1991 work incident "independently contributed to a worsening of her condition and was the major contributing cause of the need for medical treatment and authorization of time loss after March 20, 1991." (Ex. 30). That concurrence is more than enough to prove material causation.

According to his March 21, 1991 chart note, McIntyre examined claimant and considered her description of low back symptoms. Based upon his evaluation, McIntyre diagnosed a repeat strain of the low back, released her from work and prescribed pain medication. (Ex. 24A). Based on the forgoing evidence, we conclude that claimant sustained a new compensable injury in March 1991, which is established by medical evidence supported by objective findings. See Georgia-Pacific Corp. v. Ferrer, 114 Or App 471 (1992). Consequently, responsibility for claimant's condition shifts to CLA. See ORS 656.308(1).

Because claimant's right to compensation was at risk at hearing, claimant is entitled to an assessed attorney fee for services rendered on Board review pursuant to ORS 656.382(2). See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248 (1992). 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 \$600, to be paid by CLA. 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 23, 1992 is affirmed. Claimant's attorney is awarded \$600 for services on Board review, to be paid by Continental Loss Adjusting Services.

November 30, 1992

Cite as 44 Van Natta 2391 (1992)

In the Matter of the Compensation of
RICHARD L. VEATCH, Claimant

WCB Case No. 91-17108

ORDER ON REVIEW

Brasch & Associates, Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerbund.

Claimant requests review of Referee Brazeau's order that upheld the SAIF Corporation's partial denial of claimant's claim for a C5-6 cervical condition as related to an accepted claim for a February 13, 1990 strain injury. On review, the issue is compensability.

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

Claimant's claim for a February 13, 1990 injury to his neck and low back was accepted by Stipulation. The claim was closed by an October 18, 1990 Determination Order which awarded temporary and permanent disability benefits. On November 13, 1990, claimant allegedly suffered a second work injury affecting his neck. The parties settled the claim for the second injury with a Disputed Claim Settlement (DCS), which provided that SAIF's denial of the November 13, 1990 injury would stand. Thereafter, claimant submitted claims for C5-6 surgery and related disability. SAIF responded with a partial denial on October 7, 1991, stating that claimant's cervical condition is not

compensable because the major cause was the "intervening" noncompensable injury of November 13, 1990. (Ex. 35).

Because claimant is seeking compensation for a worsened condition resulting from the original February 13, 1990 injury and the worsening occurred after claim closure, we agree with the Referee's determination that ORS 656.273 applies. On this record, we further agree that the November 13, 1990 injury was the major contributing cause of claimant's disability and need for treatment for his C5-6 disc condition. See David K. Boyer, 43 Van Natta 561 (1991), aff'd mem, 111 Or App 666 (1992) (A major contributing cause is one that contributes more to the claimed condition than all other causes, explanations or exposures combined). By virtue of the DCS, the November 13, 1990 injury is a noncompensable causal factor. Therefore, SAIF has carried its burden of proving that the noncompensable, or "off-work" injury, is the major contributing cause of the claimed current condition and consequently, the claim is not compensable under ORS 656.273(1). See Roger D. Hart, 44 Van Natta 2189 (1992).

Finally, we note claimant's theory of the case that his claim is for an "initial injury" rather than for an aggravation. In this regard, claimant argues that his current claim is compensable if his disability and need for treatment for his neck is materially related to the accepted February 13, 1990 injury claim. We disagree.

Even assuming, arguendo, that this claim is properly analyzed under ORS 656.005(7)(a) rather than ORS 656.273(1), there is no evidence that claimant's current cervical condition is a direct or primary consequence of the accepted February 1990 claim. Instead, any relationship between the initial injury and the current condition is indirect or "consequential" via the intervening injury, at best. Therefore, if ORS 656.005(7)(a) were applicable, the limitation of subsection A would also apply and claimant would be subject to the "major contributing cause" standard of proof. See Julie K. Gasperino, 43 Van Natta 1151 (1991), aff'd Albany General Hospital v. Gasperino, 113 Or App 411 (1992). Moreover, because the intervening November 1990 injury is the major contributing cause of the claimed condition, claimant's argument does not inure to his benefit. See David K. Boyer, supra.

ORDER

The Referee's order dated March 9, 1992 is affirmed.

December 1, 1992

Cite as 44 Van Natta 2392 (1992)

In the Matter of the Compensation of
NANCY C. GOFF, Claimant
 WCB Case No. 90-08877
 ORDER ON RECONSIDERATION
 Malagon, et al., Claimant Attorneys
 Janelle Irving (Saif), Defense Attorney

On November 6, 1992, we reversed that portion of a Referee's order that directed the SAIF Corporation to pay claimant's scheduled permanent disability award at a rate of \$305 per degree. The parties have submitted a proposed "Stipulation and Order," which is designed to resolve the rate of scheduled permanent disability issue. We treat this submission as a motion for reconsideration, which we grant. After conducting our review, we issue the following order.

Pursuant to the stipulation, the parties agree that claimant's scheduled permanent disability award shall be paid at a rate of \$145 per degree unless and until there is an ultimate appellate determination providing that awards such as claimant's shall be paid at a rate of \$305 per degree. We have approved the parties' stipulation, thereby fully and finally resolving this issue.

In reaching this decision, we note that the stipulation provides that this matter shall not be dismissed until the Supreme Court's decision in SAIF v. Herron, 114 Or App 64 (1992). Inasmuch as such a provision is contrary to our holding in John B. Gordon, 44 Van Natta 1601 (1992), this case shall not remain pending before us. Rather, those portions of our prior order which pertained to the rate of

claimant's scheduled permanent disability have been replaced by the aforementioned stipulation. The remaining portions of our prior order shall remain unchanged.

Accordingly, our November 6, 1992 order is withdrawn. On reconsideration, as modified herein, we republish our November 6, 1992 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

December 1, 1992

Cite as 44 Van Natta 2393 (1992)

In the Matter of the Compensation of
JUDY A. JACOBSON, Claimant
WCB Case No. 91-16843
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Moller and Brazeau.

The insurer requests review of Referee Mills' order that: (1) found that the temporary rules adopted in WCD Admin. Orders 15-1990 and 20-1990 were invalid; (2) increased claimant's unscheduled permanent disability award for a back injury from 10 percent (32 degrees), as awarded by an Order on Reconsideration, to 17 percent (54.4 degrees); and (3) awarded 3 percent (4.5 degrees) scheduled permanent disability for the loss of use or function of claimant's right leg. Claimant, in her respondent's brief, alleges that she is entitled to increased unscheduled permanent disability. On review, the issues are validity of the rules and extent of unscheduled and scheduled permanent disability. We reverse in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Validity of Rules

Because claimant was declared medically stationary after July 1, 1990 (on February 8, 1991) and the Determination Order issued on March 15, 1991, in determining the extent of permanent disability, claimant falls under the temporary rules promulgated in WCD Admin. Orders 15-1990 and 20-1990. See former OAR 436-35-003 (WCD Admin. Orders 15-1990, 20-1990, and 2-1991). However, the Referee found that the rules contained in WCD Admin. Orders 15-1990 and 20-1990 were invalid and instead applied the rules promulgated in WCD Admin. Order 6-1988. The insurer asserts that the temporary rules are valid.

Subsequent to the Referee's order, we examined our authority to determine the validity of the temporary standards. In Eileen N. Ferguson, 44 Van Natta 1811, 1812 (1992), we found that, under ORS 183.400(1), (2), and (4), the validity of a rule could be challenged by petition to "the court" or "the agency." Finding that the Board qualified neither as "the court" nor, because we were not the agency that promulgated the rule in question, as "the agency" under the statutes, we concluded that we have no authority to declare the temporary standards to be invalid. Id.

Therefore, we are statutorily required to apply the standards adopted by the Director at the relevant time. ORS 656.295(5); Eileen N. Ferguson, supra. See also Edmunson v. Dept. of Insurance and Finance, 314 Or 291 (1992). As we found above, the standards applicable to this case are those contained in WCD Admin. Orders 15-1990 and 20-1990. Thus, we address the extent of claimant's entitlement to permanent disability under those rules.

Extent of Unscheduled Permanent Disability

The insurer next contends that, under the temporary standards, claimant is entitled to 10 percent unscheduled permanent disability, as awarded by the Order on Reconsideration.

We conclude that application of the temporary standards does not change the Referee's findings regarding impairment, and age and education. However, we agree with claimant that she is entitled to an adaptability factor of 4. Adaptability is rated according to claimant's work status at and before the mailing date of the Determination Order. Heather I. Smith, 44 Van Natta 2207 (1992); Vickie M. Libel, 44 Van Natta 413 (1992). Here, on the date of the Determination Order, claimant was not working, had not been released to regular employment, and had not been offered modified work, although she had been released to light duty. (Ex. 6-1). Therefore, claimant falls under former OAR 436-35-310(4), which provides for an adaptability value of 4.

We proceed to compute claimant's unscheduled permanent disability. Claimant's age and education values total 4. That value multiplied by claimant's adaptability value of 4 equals 16. When that value is added to claimant's impairment value of 9, the result is 25 percent unscheduled permanent disability.

Scheduled Permanent Disability

The insurer next challenges the insurer's scheduled disability award. The insurer first asserts that claimant did not raise the issue of scheduled disability during the reconsideration process and, therefore, should have been precluded from raising it before the Referee.

Whether a party has raised an objection in a request for reconsideration is a factual question. See Dale A. Pritchett, 44 Van Natta 2134 (1992). We agree with the Referee that the issue was raised during reconsideration. On the request for reconsideration, claimant marked that she was challenging the impairment findings and the rating of unscheduled permanent disability. (Ex. 17A-1). On an addendum, claimant indicated that her challenges were based on "sensory loss and numbness from the hip to the knee" that had not been addressed by any previous medical opinion. (Id. at 2). The medical arbiter, Dr. Sacamano, noted a "marked hypesthesia" on claimant's right leg, diagnosing "meralgia paresthetica". (Ex. 17-3). The Order on Reconsideration addressed this condition, finding no entitlement to impairment values. (Ex. 18-5).

Claimant's incorrect identification on reconsideration of the condition as unscheduled disability should not prevent her from litigating it as scheduled disability at hearing. See Pritchett, supra. Rather, we find that because claimant raised the issue of disability based on her right leg condition and that issue was addressed by both the medical arbiter and the Order on Reconsideration, the Referee properly determined impairment of the right leg condition.

The insurer next asserts that claimant failed to prove that her meralgia paresthetica condition was related to the industrial injury. That contention is disproved by Dr. Sacamano, who reported that the condition was "secondary to industrial injury." (Ex. 17-3).

The insurer further asserts that there is no proof of atrophy based on the right leg condition, that sensory loss is not entitled to a rating unless due to a compensable nerve root injury and that motor loss or weakness does not receive a rating under the standards. We agree that, under former OAR 436-35-230(1) (WCD Admin. Order 6-1988), "loss of surface sensation in the leg is not considered disabling." That rule was not changed by the temporary standards. However, under former OAR 436-35-230(5)(b), which also was not amended by the temporary rules, weakness or atrophy is entitled to a rating "when objective findings are in the thigh."

Claimant contends that she proved weakness based on Dr. Sacamano's finding of motor power in the dorsiflexors as 5/5 on the left and 4/5 on the right and that she proved atrophy based on Dr. Sacamano's finding of thigh circumference on the right as 45.2 centimeters compared to 46.5 centimeters on the left. In reviewing Dr. Sacamano's report, there is an absence of evidence that these findings were due to the meralgia paresthetica condition. Therefore, we conclude that claimant is not entitled to

a rating under former OAR 436-35-230(5)(b). Having found no other basis for awarding impairment for the right leg condition, we conclude that claimant is not entitled to scheduled disability.

Attorney Fee on Review

Claimant is entitled to an assessed attorney fee for prevailing against the insurer's request for review regarding unscheduled permanent disability. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee regarding this issue is \$500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated March 11, 1992 is reversed in part and modified in part. The Referee's 3 percent (4.5 degrees) scheduled permanent disability award is reversed. In addition to claimant's prior awards totalling 17 percent (54.4 degrees) unscheduled permanent disability, claimant is awarded 8 percent (25.6 degrees), giving her a total award to date of 25 percent (80 degrees) unscheduled permanent disability. In lieu of the Referee's attorney fee award, claimant's attorney is awarded 25 percent of the increased unscheduled permanent disability award granted by the Referee and Board order, not to exceed \$3,800. For services on review concerning the issue of unscheduled permanent disability, claimant's attorney is awarded an assessed fee of \$500.

December 2, 1992

Cite as 44 Van Natta 2395 (1992)

In the Matter of the Compensation of
DONALD A. CLARK, Claimant
WCB Case No. 90-21123
ORDER ON REVIEW
Moscato, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

Claimant, pro se, requests review of Referee Hoguet's order that upheld the insurer's denial of claimant's injury claim for a collapsed lung. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

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

On April 21, 1990, claimant suffered a left tension pneumothorax (collapsed lung) while lifting a box at work. On September 26, 1990, the insurer issued a denial, denying that claimant's collapsed lung arose out of and in the course of his employment.

Claimant's lifting incident at work was a material contributing cause of his immediate need for medical treatment. The work incident combined with claimant's preexisting, congenital "blebs" condition to cause or prolong his disability and need for treatment. The major contributing cause of his resultant disability and need for treatment was the preexisting congenital blebs condition.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded from the medical evidence that the major contributing cause of claimant's collapsed lung condition was his preexisting, congenital "blebs" condition, or blistering of the lungs. The Referee, therefore, upheld the insurer's denial and found claimant's condition to be not compensable. The Referee did not distinguish between the compensability of claimant's initial lifting incident and his resultant condition, however.

In Bahman M. Nazari, 43 Van Natta 2368 (1991), we held that pursuant to ORS 656.005(7)(a), a worker may establish the compensability of a work-related accident by proving that the accident was a material contributing cause of his disability or need for treatment. See Mark N. Weidle, 43 Van Natta 855 (1991). We further held, however, that subsection (B) of the statute places a limitation on the compensability of a worker's resultant condition where his work injury combines with a preexisting condition or disease to cause or prolong disability or need for treatment. Under such circumstances, the worker must prove that the compensable injury is and remains the major contributing cause of the disability or need for treatment. Thus, although the initial injury may be compensable, the worker may not be entitled to claimed compensation for particular medical services or disability if his preexisting condition is the major cause thereof.

We further held in Nazari that an insurer should not deny an initial injury claim for the purpose of taking advantage of the limiting feature of subsection (B). Rather, the insurer should accept the initial claim as compensable under ORS 656.005(7)(a). Then, if it reasonably believes that the worker's treatment and disability are caused in major part by his preexisting condition rather than the compensable injury, the insurer may issue a partial denial of such treatment and disability. In the appropriate case, a carrier may accept an injury and partially deny disability and treatment in a single document.

In the present case, we agree with the Referee's reliance on the opinion of Dr. Blair, who opined that, but for claimant's work incident, he would not have suffered a collapsed lung at the time he did. We find from Blair's opinion that claimant's work incident was a material contributing cause of his initial need for medical treatment. ORS 656.005(7)(a). The insurer's denial is, therefore, set aside insofar as it denies that claimant's collapsed lung arose out of and in the course of his employment.

Dr. Blair could not determine, however, whether it was claimant's work incident or his preexisting lung condition that constituted the major contributing cause of his disability and need for treatment. From this evidence, we conclude that claimant has failed to prove the compensability of his resultant disability and need for treatment. ORS 656.005(7)(a)(B). Accordingly, although claimant has established that he suffered a compensable injury on April 21, 1990, his subsequent medical treatment following his initial need for treatment for his collapsed lung and his resultant disability are not compensable.

Attorney Fees

Although claimant appears pro se on review, he was represented by counsel at hearing. By way of this order, we have found that claimant's industrial accident is compensable. Claimant's attorney was instrumental in establishing the facts at hearing that led to our ultimate conclusion. An assessed attorney fee, therefore, is appropriate. 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 attorney fee for claimant's attorney's services at hearing is \$1,000. In reaching this conclusion, we have particularly considered the time devoted to the issues at hearing, as reflected by the record, the complexity of the issues and the value of the interest to claimant.

ORDER

The Referee's order dated June 27, 1991 is reversed in part and affirmed in part. The insurer's denial is set aside insofar as it denies the compensability of claimant's lifting incident at work, and the injury claim is remanded to the insurer for acceptance and processing according to law. For services at hearing, claimant's attorney is awarded a reasonable attorney fee of \$1,000, to be paid by the insurer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
BRENDA K. ALLEN, Claimant
WCB Case No. 91-08314
ORDER OF ABATEMENT
Galton, et al., Claimant Attorneys
Stoel, et al., Defense Attorneys

The self-insured employer requests reconsideration of our November 10, 1992 order that set aside its denial of claimant's occupational disease claim insofar as it pertained to a mental disorder. Contending that our order contains several factual and legal errors, the employer seeks the reinstatement of its denial in its entirety.

In order to consider the employer's motion, we withdraw our November 10, 1992 order. 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, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
KELLY M. DAVIS, Claimant
WCB Case No. 91-12878
CORRECTED ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

It has come to our attention that our Order on Review, dated November 25, 1992, contains an omission. Specifically, the order omitted the fact that in addition to the March 7, 1991 Determination Order, the August 26, 1991 Order on Reconsideration was also set aside as premature. As corrected herein, we adhere to and republish our November 25, 1992 order. The parties' rights of appeal shall continue to run from the date of our November 25, 1992 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ELLA M. DeCOTEAU, Claimant
WCB Case Nos. 91-16356 & 91-16355
ORDER OF ABATEMENT
Francesconi & Associates, Claimant Attorneys
Davis & Bostwick, Defense Attorneys
Cummins, et al., Defense Attorneys

On November 13, 1992, we dismissed Cigna Insurance's request for review of a Referee's order that: (1) set aside its denial of claimant's occupational disease claim for a right carpal tunnel syndrome condition; and (2) set aside Alexsis Risk Management's denial of an occupational disease claim for a right wrist tendinitis condition. (Parenthetically, we note that our order inaccurately stated that Alexsis denial of an aggravation claim had been upheld. By this order, we correct that clerical error). Our dismissal order was issued in accordance with a "Disputed Claim Settlement" between claimant and Cigna, which we had approved.

We have now received a proposed "Disputed Claim Settlement" concerning claimant's claim with Alexsis. We treat such a submission as a request for reconsideration. We grant the request and withdraw our prior order.

We have no objection to those portions of the proposed settlement which seek to resolve the compensability of claimant's current right upper extremity condition because it appears that a bona fide dispute between claimant and Alexsis concerning the compensability of that condition exists. See ORS 656.289(4); OAR 438-09-010(2). Nevertheless, Board approval of the settlement cannot be granted because the proposed attorney fee is not in compliance with applicable rules.

Absent extraordinary circumstances, attorney fees in disputed claim settlements are limited to 25 percent of the first \$12,500, plus 10 percent of any amount in excess of \$12,500. OAR 438-15-050. Here, the settlement proceeds total \$1,000. Thus, in accordance with the aforementioned rule, claimant's attorney fee would be \$250. (25 percent of \$1,000).

Yet, the agreement provides that claimant's attorney shall receive the \$2,000 fee granted by the Referee's order. Since Alexsis' denial is being upheld in the settlement, it follows that the statutory basis for the Referee's attorney fee award (prevailing against the denial) has been eliminated. Furthermore, the settlement does not contain a contention supporting "extraordinary circumstances." See OAR 438-15-050. Lacking such a contention and Board finding, the presently proposed attorney fee cannot be approved.

Because the agreement fails to comply with the aforementioned rules, it is being returned to the parties for revision. We would be willing to consider a proposed agreement drafted in compliance with our rules and the matters discussed herein. Pending our receipt of a revised agreement, our November 13, 1992 dismissal order shall remain abated.

In issuing this abatement order, we wish to emphasize that we continue to adhere to our approval of the settlement between claimant and Cigna. Our conclusions regarding that particular settlement shall not be changed. However, this abatement order is necessary to retain our jurisdiction over this case to enable us to consider the revised settlement between claimant and Alexsis. Once we have received that revised agreement and have granted our approval, we shall issue an amended order of dismissal finally dismissing all issues in this case.

IT IS SO ORDERED.

In the Matter of the Compensation of
GABRIEL M. GONZALES, Claimant
WCB Case No. 91-09902
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of that portion of Referee McCullough's order that declined to require the SAIF Corporation to pay an approved attorney fee awarded by an amended Order on Reconsideration. On review, the issue is attorney fees.

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

A July 17, 1991 Order on Reconsideration increased claimant's unscheduled permanent partial disability from 9 percent (28.8 degrees) to 17 percent (54.4 degrees). The Order on Reconsideration indicated that attorney fees were not payable because claimant had not submitted a valid attorney retainer agreement as required by former OAR 436-30-050(16).

The relevant portion of former OAR 436-30-050(16) provided: "Attorney fees may only be authorized when a request for reconsideration is submitted by an attorney representing a worker and a valid signed retainer agreement has been filed with the Appellate Unit."

On July 22, 1991, SAIF sent claimant the full amount of the permanent disability award granted by the Order on Reconsideration. On July 31, 1991, the Appellate Unit issued an amended Order on Reconsideration which stated that the July 17, 1991 Order on Reconsideration was being amended because claimant had submitted an attorney retainer agreement. The amended Order on Reconsideration ordered SAIF to pay the attorney of record a fee of \$256 out of, and not in addition to, the additional permanent disability award.

The Referee held that claimant's attorney must obtain payment of the fee ordered by the July 31, 1991 amended reconsideration order from claimant, not SAIF. We agree.

In Kenneth V. Hambrick, 43 Van Natta 1636 (1991), a referee's order failed to approve a fee out of compensation and claimant did not request such a fee until reconsideration at the Board level. In that case, we held that the carrier had no duty to pay an out-of-compensation fee directly to claimant's attorney. We further concluded that if the carrier had already paid the compensation as ordered, it would be inequitable to require the carrier to now pay a fee as a result of the referee's error and the claimant's failure to timely request correction of the error.

Here, SAIF promptly complied with the Order on Reconsideration and paid the entire award to claimant pursuant to that order. Furthermore, the amended order did not order SAIF to pay an additional fee of \$256, rather it ordered SAIF to pay the fee out of the compensation awarded by the earlier order. That award had already been paid.

As noted by the Referee, carriers may be penalized under the law for failing to timely pay compensation due an injured worker. Inasmuch as the reason for the reconsideration order's failure to award a fee was the failure of claimant's attorney to submit a fee agreement as required by OAR 436-30-050(16), we decline to now require SAIF to pay a separate fee in addition to the compensation already paid. Therefore, under these facts, we agree with the Referee that claimant's attorney must seek payment of his attorney fee from claimant rather than from the carrier.

ORDER

The Referee's order dated March 27, 1992, as reconsidered April 29, 1992, is affirmed.

In the Matter of the Compensation of
WILLIAM L. LARIMORE, Claimant
WCB Case No. 91-07393
ORDER ON REVIEW
Pozzi, Wilson, et al., Claimant Attorneys
Lindsay, Hart, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant's beneficiary requests review of Referee Spangler's order which dismissed the beneficiary's hearing request concerning the Workers' Compensation Division's (WCD's) refusal to determine whether the beneficiary's deceased husband was a subject worker. On review, claimant's beneficiary contends that, in effect, the Referee was authorized to issue a final order on behalf of the Director concerning the beneficiary's objection to WCD's "subject worker" determination.

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

On November 29, 1990, claimant was fatally injured while allegedly working for the employer. Claimant's beneficiary, his widow, filed a claim for death benefits and requested the Department of Insurance and Finance to determine whether the employer was noncomplying. After an investigation, the Department informed the beneficiary that the claim could not be processed, because it could not determine whether claimant was a subject worker at the time of his injury. The letter further notified the beneficiary of her right to a hearing before the Department, which she timely requested. On June 11, 1991, she also requested a hearing before the Hearings Division of this Board.

Pursuant to the June 11, 1991 hearing request, a hearing was convened on September 9, 1991. The Referee concluded that the Hearings Division lacked jurisdiction to resolve the dispute over whether claimant was a subject worker and, accordingly, dismissed the request for hearing. On October 7, 1991, the beneficiary requested Board review. On November 26, 1991, the beneficiary also filed a petition with the Court of Appeals, seeking judicial review of the Referee's order. That petition presently remains pending before the court.

On Board review, claimant's beneficiary asks that the Referee's order be reversed and remanded for hearing. Noting that the Department has not taken action on her other hearing request, claimant's beneficiary contends that the Referee essentially sat as the Department's designee regarding that hearing request. Consequently, claimant's beneficiary asserts that the Referee was authorized to consider the hearing request.

Had the hearing in this case convened on or after April 15, 1992, we would concur with claimant's beneficiary's assertion that the Referee was authorized to review WCD's "nonsubjectivity" determination. We would reach such a conclusion because on that date OAR 438-06-038 became effective. (Temp. rule, WCB Admin. Order 2-1992). By that rule, the Board codified its intra-agency agreement with WCD which provided that challenges to WCD's "nonsubjectivity" determinations would be heard before the Hearings Division. (Parenthetically, we note that OAR 438-06-038 has been adopted as a permanent rule. (WCB Admin. Order 6-1992, effective October 12, 1992)).

Here, at the time of the September 9, 1991 hearing, the aforementioned agreement and rule did not exist. Therefore, administrative review of WCD's "nonsubjectivity" determination rested with the Director. See former OAR 436-80-060(3). Under such circumstances, the Referee was without authority to review WCD's determination.

Nevertheless, the record suggests that claimant's beneficiary's challenge to WCD's "nonsubjectivity" determination remains pending before the Director. Thus, in accordance with the intra-agency agreement and the aforementioned administrative rules, we trust that either claimant's beneficiary's WCD hearing request will be referred to our Hearings Division or that claimant's beneficiary will file another hearing request contesting WCD's "nonsubjectivity" determination. See OAR 436-80-060(3); OAR 438-06-038.

ORDER

The Referee's order dated September 30, 1991 is affirmed.

December 3, 1992

Cite as 44 Van Natta 2401 (1992)

In the Matter of the Compensation of
STEVEN E. PARKER, Claimant
WCB Case No. 91-12035
ORDER ON REVIEW (REMANDING)
Whitehead, et al., Claimant Attorneys
Lester R. Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Moller.

Claimant requests review of Referee Michael V. Johnson's order that dismissed claimant's request for hearing for lack of jurisdiction. On review, the issue is validity of the Order on Reconsideration. We remand.

PRELIMINARY MATTER

In the heading, the Referee's order erroneously provides the WCB Case No. as 92-12035. We correct that portion of the order to provide WCB Case No. 91-12035.

FINDINGS OF FACT

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

In requesting reconsideration, claimant objected to the impairment findings used in rating claimant's disability. (See Ex. 13-1). After the Order on Reconsideration issued, the Medical Review and Abuse Section received the medical arbiter's report. (See Ex. 14).

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 findings 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 or submit the arbiter's findings for reconsideration. See Olga I. Soto, 44 Van Natta 697, 700, recon den 44 Van Natta 1609 (1992).

However, the Director's failure to comply with this mandatory procedure results in a voidable order, rather than one that is void ab initio. Brenton R. Kusch, 44 Van Natta 2222 (1992). The party that requested reconsideration of a Notice of Closure or Determination Order and objected to the impairment findings may, at hearing, withdraw any objection to the impairment findings and thereby waive its right to examination by a medical arbiter. In such cases, the Order on Reconsideration is not declared invalid. See Randy M. Mitchell, 44 Van Natta 2304 (1992). However, if the party requesting reconsideration continues to object to the impairment findings at hearing, then the Order on Reconsideration is declared invalid. Id. Furthermore, a party that does not request reconsideration or object to the impairment findings during the reconsideration process is precluded at hearing from moving to dismiss the request for hearing on the basis that the Order on Reconsideration is invalid because the Director failed to appoint a medical arbiter. See id.

In this case, claimant objected to the impairment findings in his request for reconsideration. However, there is no evidence as to whether claimant withdrew his objections to the impairment findings at hearing. Furthermore, although it appears that SAIF objected to the Order on Reconsideration because no medical arbiter had been appointed, there is no evidence as to whether or not SAIF also requested reconsideration or objected to the impairment findings during reconsideration.

Therefore, we conclude that the record is insufficiently developed regarding whether claimant withdrew his objections to the impairment findings or if SAIF could object to the Order on Reconsideration. See ORS 656.295(5). Consequently, we vacate the Referee's order. We remand to the Referee to admit evidence regarding SAIF's objections, if any, during reconsideration regarding the Determination Order and to make findings as to whether or not claimant withdrew his objections to the impairment findings. If SAIF did not object to the impairment findings during reconsideration and claimant withdrew such objections at hearing, then the Order on Reconsideration is not invalid and the Referee should proceed to address the issues raised by claimant's request for hearing.

ORDER

The Referee's order dated April 17, 1992 is vacated. This matter is remanded to Referee Michael V. Johnson for further proceedings consistent with this order.

December 3, 1992

Cite as 44 Van Natta 2402 (1992)

In the Matter of the Compensation of
SUSAN N. TODD, Claimant
 WCB Case No. 92-03294
 ORDER ON REVIEW
 Olson, Rowell & Walsh, Claimant Attorneys
 Rick Dawson (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

The SAIF Corporation requests review of Referee Schultz' order that directed it to pay claimant's scheduled permanent disability awards at the rate of \$305 per degree. Claimant cross-requests review, contending that the Referee erred in failing to award an approved attorney fee. On review, the issues are the Referee's authority to abate and reconsider his order, rate of scheduled permanent disability and attorney fees. We reverse.

FINDINGS OF FACT

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

The Referee's order issued June 8, 1992. On June 12, 1992, SAIF requested Board review. On June 17, 1992 claimant requested reconsideration by the Referee asserting entitlement to an attorney fee. On June 23, 1992, the Referee issued an "Order of Abatement and Reconsideration" which purported to award claimant's counsel an out-of-compensation attorney fee. On June 25, 1992, claimant cross-requested Board review, requesting an attorney fee.

ULTIMATE FINDING OF FACT

SAIF filed its request for Board review of the Referee's June 8, 1992 order before the Referee abated the order for reconsideration.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we consider the effect of the Referee's June 23, 1992 Order of Abatement and Reconsideration and conclude that it has none.

Upon filing of a request for Board review of a Referee's order, jurisdiction over the case vests with the Board. See ORS 656.295; OAR 438-05-046(1)(b); Ramey S. Johnson, 40 Van Natta 370 (1988). Thus, when SAIF filed its request for Board review in this case, the Referee was without authority to further consider this matter. See OAR 438-07-025(1); Ramey S. Johnson, supra. Because the Referee lacked authority to abate and reconsider this matter, his June 23, 1992 order on reconsideration is a

nullity. Id. Consequently, pursuant to the request and cross-request for review, only the June 8, 1992 order is presently before us.

On the merits, 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).

Finally, because claimant has not established entitlement to additional compensation, there is no basis for an attorney fee award in this case.

ORDER

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

December 3, 1992

Cite as 44 Van Natta 2403 (1992)

In the Matter of the Compensation of
GALVIN C. YOAKUM, Claimant
WCB Case No. 91-16041
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of that portion of Referee Neal's order that declined to address claimant's contention regarding temporary total disability benefits on the basis of lack of jurisdiction. On review, the issue is jurisdiction. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the last two paragraphs and provide the following supplementation.

On November 5, 1991, claimant filed a request for hearing alleging a de facto denial of temporary total and partial disability benefits. The hearing was scheduled for February 12, 1992.

On December 20, 1991, a Determination Order issued awarding temporary total disability from October 24, 1989 through October 8, 1991 "less any time that the worker has withdrawn from the workforce." (Ex. 65). The order also awarded 20 percent unscheduled permanent disability and approved deduction of overpaid temporary total disability, if any, from unpaid unscheduled permanent disability. (Id.)

Prior to the issuance of the Determination Order, the insurer had paid claimant temporary total disability through March 5, 1991. (Ex. 48). After the Determination Order issued, the insurer, based on its contention that claimant had retired from the work force on April 1, 1991, calculated an overpayment of \$15,034.33. (Ex. 66). It applied this amount to claimant's unscheduled disability award of \$6,400, the balance to be applied to any future orders. (Id.)

On February 20, 1992, the insurer requested reconsideration of the Determination Order. On April 8, 1992, the Order on Reconsideration issued.

CONCLUSIONS OF LAW AND OPINION

The Referee found that she lacked jurisdiction to consider claimant's request for review because the Determination Order had not yet been through the reconsideration process. Claimant agrees that the Referee did not have jurisdiction to address whether he was entitled to greater permanent or temporary disability under the Determination Order. However, claimant asserts that he was not objecting to the Determination Order. Rather, claimant maintains that his request for hearing was based on the insurer's failure to pay temporary disability while the claim was open because, according to the insurer, claimant had withdrawn from the work force.

We recently considered the jurisdiction of the Board and Hearings Division regarding the award of temporary disability by a Determination Order when neither party had requested reconsideration, and an Order on Reconsideration had not issued, regarding the Determination Order. See Mindi M. Miller, 44 Van Natta 2144 (1992). We found that we have jurisdiction to enforce the award of temporary disability despite the absence of reconsideration of the Determination Order by the Department. Id. at 2145. However, if the claimant is seeking to modify the award of temporary disability, then the claimant must first seek reconsideration of the Determination Order before the Board and Hearings Division have jurisdiction to consider the claimant's requests for hearing and review. Id.

Based on Miller, we agree with the Referee that we would lack jurisdiction in this case regarding the temporary disability issue if claimant was seeking to modify the Determination Order's temporary disability award. However, unlike the claimant in Miller, claimant here filed his request for hearing before the issuance of the Determination Order and there was no subsequent attempt by claimant to include the Determination Order in his request for hearing after it issued. Furthermore, his request for hearing addressed the insurer's unilateral termination of temporary disability, which also occurred before the Determination Order issued. Under these circumstances, we find that claimant was not seeking to modify the Determination Order's award of temporary disability, but instead was objecting to the termination of such benefits while the claim was in open status.

Under ORS 656.268(5), the Hearings Division lacks initial jurisdiction to address direct challenges to a Notice of Closure or Determination Order regarding an injured worker's substantive entitlement to temporary disability. Ralph E. Fritz, 44 Van Natta 1168 (1992). However, a Referee has original jurisdiction over disputes concerning an injured worker's procedural entitlement to temporary disability, because that issue is ripe for adjudication prior to claim closure. See also Steven V. Bischof, 44 Van Natta 255, on recon, 44 Van Natta 433 (1992), aff'd mem Freightliner Corporation v. Bischof, 115 Or App 758 (1992). As discussed above, claimant is objecting to the insurer's unilateral termination of temporary disability while the claim was in open status. Therefore, we conclude that claimant's request for hearing concerned his procedural entitlement to temporary disability and, consequently, we have jurisdiction.

An insurer may procedurally terminate temporary disability without the claimant being medically stationary if any one of the conditions set forth in ORS 656.268(3) are met. See Soledad Flores, 43 Van Natta 2504 (1991). These conditions include the worker's return to regular or modified employment, the receipt by the worker of a written release by his attending physician to return to regular employment, and the receipt by the worker of a written release by his attending physician to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment.

The record reveals that none of the above conditions occurred, warranting the insurer to unilaterally terminate temporary disability. Rather, the insurer stopped paying such benefits because it concluded that claimant had withdrawn from the work force. Although withdrawal from the work force can serve as a basis for denying a claimant's substantive entitlement to temporary disability, it does not justify unilaterally terminating a claimant's procedural entitlement to temporary disability. See Esther C. Albertson, 44 Van Natta 521, 522-23 (1992). Therefore, because ORS 656.268(3) was not satisfied, the insurer lacked authority to unilaterally terminate claimant's temporary disability.

We wish to emphasize that our order is limited to claimant's procedural entitlement to temporary disability. We, therefore, provide no opinion regarding whether or not claimant withdrew from the work force since, as discussed above, that issue concerns claimant's substantive entitlement to temporary disability which is a matter arising from the closure of claimant's claim. Should it be subsequently concluded that our procedural temporary disability award created an overpayment, the insurer may seek authorization to offset that overpayment against claimant's permanent disability awards.

Finally, we note that claimant is not entitled to an assessed attorney fee under ORS 656.386(1) for services at hearing and on review. That statute is applicable only for "denied claims" when the parties are disputing whether the claimant's condition was caused by an industrial injury. Short v. SAIF, 305 Or 541, 545 (1988). When the only issue on appeal is the amount of compensation, such as this case, ORS 656.386(1) is not applicable. Id. However, claimant is entitled to an attorney fee pursuant to ORS 656.386(2). We approve a fee of 25 percent of any increased compensation created by this order, not to exceed \$3,800, to be paid out of the increased compensation. See OAR 438-15-055.

ORDER

The Referee's order dated February 25, 1992 is reversed in part. On a procedural basis, claimant is awarded temporary disability payable from March 5, 1991 until this compensation could be lawfully terminated. Claimant's attorney is awarded 25 percent of this increased compensation created by this order, not to exceed \$3,800, to be paid out of the increased compensation. The remainder of the Referee's order is affirmed.

December 4, 1992

Cite as 44 Van Natta 2405 (1992)

In the Matter of the Compensation of
THOMAS A. HUTCHESON, Claimant
WCB Case No. 91-16385
ORDER DENYING RECONSIDERATION
Westmorland & Shebley, Claimant Attorneys
Roberts, et al., Defense Attorneys

Claimant requests reconsideration of our October 19, 1992 Order on Review, as reconsidered November 18, 1992, that reversed the Referee's order setting aside the insurer's denial of claimant's current low back condition. Claimant also moves to remand the matter to the Referee for submission of additional evidence. For the following reasons, we deny the motion to remand and adhere to our prior conclusions.

The issue in this case was whether claimant proved that his current condition was compensable under ORS 656.005(7)(a)(B). In our Order on Review and Order on Reconsideration, we concluded that claimant failed to carry his burden to establish that his current condition was, in major part, caused by his industrial back injuries of October and December 1990 rather than his preexisting degenerative condition. Our prior orders also discussed our finding that reports submitted by claimant's treating physician, Dr. Nash, although indicating that claimant suffered from a nerve root entrapment, provided no opinion as to the cause of the condition nor addressed the relative contributions of claimant's industrial injuries and preexisting conditions to his current symptoms.

Under ORS 656.295(5), we may remand a 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, claimant moves for remand in order to admit additional evidence regarding claimant's surgery following the hearing and his condition after surgery. Specifically, the evidence consists of an operative report by Dr. Nash indicating evidence of nerve root compression, a report by Dr. Misko, neurological surgeon, who examined claimant upon referral from Dr. Nash and stated that claimant has recurrent disc protrusion at L4-5, a request for authorization of surgery by Dr. Nash to remove the recurrent L4-5 disc, and the insurer's denial of the request for surgery.

Although this evidence was not obtainable at the time of hearing and concerns claimant's disability, we conclude that claimant has failed to show a compelling reason to warrant remand for submission of this evidence. Although the operative report from Dr. Nash may confirm his diagnosis regarding nerve root entrapment, it suffers from the same defect as those reports admitted at hearing. That is, it provides no opinion as to the cause of claimant's condition. Specifically, the report offers no opinion as to the relative contributions of claimant's compensable injuries and his preexisting conditions to the nerve root entrapment. Therefore, we find that this evidence is not likely to affect the outcome of the case.

Furthermore, the remaining reports pertain only to claimant's condition following surgery and Dr. Nash's request for authorization of a second surgery. Again, these reports in no way relate to the compensability of claimant's condition at the time of the hearing, which was the issue litigated at hearing. Therefore, we also find that these reports are not likely to affect the outcome of this case, although they may have some relevance if claimant decides to litigate the denial of the request for the second surgery.

Consequently, we deny claimant's motion to remand and request for reconsideration. The parties' rights of appeal shall run from the date of our November 18, 1992 Order on Reconsideration.

IT IS SO ORDERED.

December 4, 1992

Cite as 44 Van Natta 2406 (1992)

In the Matter of the Compensation of
LINDA J. SMITH, Claimant
WCB Case Nos. 91-10738 & 91-17996
ORDER OF ABATEMENT
Welch, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys
Schwabe, et al., Defense Attorneys

United Employers' Insurance seeks reconsideration of our November 12, 1992 and November 25, 1992 orders which dismissed Argonaut Insurance Company's request for Board review (in accordance with a Disputed Claim Settlement (DCS) between claimant and Argonaut) and denied United Employers' request for reconsideration of that dismissal order. Asserting that it is optimistic that a settlement of its concerns in this matter (which has apparently already been proposed to the other parties) can be achieved, United Employers requests abatement to "allow the parties to unravel this procedural tangle." Argonaut does not object to the withdrawal of our dismissal order, provided that the DCS is not set aside.

In light of these circumstances and in the interests of avoiding a potentially unnecessary appeal, we withdraw our prior orders. In issuing this withdrawal, we expressly do not alter the previously approved DCS. For the reasons set forth in our November 25, 1992 order, we do not share United Employers' concerns regarding the effect of the DCS on its interests. See also Penny L. Hanson, 43 Van Natta 2341, 2342 (1991). In any event, we are willing to retain jurisdiction to determine whether a mutually agreeable settlement can be achieved.

The parties are requested to keep us fully advised of their respective positions regarding this matter, as well as any further developments in reaching a settlement. On receipt of a revised settlement, we will proceed with our consideration of that agreement. If a revised agreement is not

achievable, we will proceed with our reconsideration and further address United Employers' contentions.

IT IS SO ORDERED.

December 4, 1992

Cite as 44 Van Natta 2407 (1992)

In the Matter of the Compensation of
CHARLES W. WOMACK, Claimant
WCB Case No. 90-15334
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Beers, et al., Defense Attorneys

Reviewed by Board Members Moller and Brazeau.

Claimant requests review of Referee Emerson's order that: (1) found that diagnostic services rendered after June 28, 1990 were not compensable; and (2) authorized the insurer to offset temporary total disability benefits paid between June and September 1988 and March 1989 and January 1990. On review, the issues are compensability of diagnostic services and offset. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability of Diagnostic Services

Claimant has an accepted claim for a back injury. Shortly after claimant returned to work as a bricklayer, he developed impotence and incontinence. Although Dr. Tiley, orthopedic surgeon, had been treating claimant, on May 1, 1990, claimant consulted Dr. Weeks, M.D. Claimant also was seen by Dr. Melgard, neurosurgeon, on referral by Dr. Tiley, as well as Dr. Elmgren, urologist, on referral by Dr. Melgard.

The Referee concluded that all medical services rendered before the insurer's June 28, 1990 denial were compensable as diagnostic services but that medical services provided after that date were not compensable because the accepted injury had been ruled out as a possible cause of claimant's impotence and incontinence. Claimant contends that the record demonstrates that all medical services rendered by the above physicians are compensable as diagnostic services. We find that some medical services performed after June 8, 1990 qualify as compensable diagnostic services.

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). Here, because there is no contention that claimant's impotence and incontinence are compensable conditions, diagnostic services are compensable only if they were rendered to determine whether or not the accepted back injury was a factor in causing those conditions.

We first conclude that all medical services rendered by Dr. Weeks after June 28, 1990 are not compensable diagnostic services. Dr. Weeks reported that "the problems of [claimant's] incontinence and impotence were not related to his back[.]" (Id.). Therefore, Dr. Weeks indicated that his treatment after June 28, 1990 was not to determine the existence of a causal relationship and, consequently, such treatment is not compensable as diagnostic services.

We further conclude that a portion of the services performed by Dr. Melgard are compensable. Dr. Melgard's initial examination of November 27, 1990 was directed at determining the etiology, including the possibility of claimant's back injury as a cause, of claimant's impotence and incontinence. He ordered an MRI of the lumbar region in that regard. (Exs. 122-2, 124). However, the record indicates that, after referring claimant to Dr. Elmgren, Dr. Melgard was not treating claimant for impotence and incontinence but instead was performing services for claimant's low back and leg problems. (Exs. 127, 129, 132). Therefore, we conclude that Dr. Melgard's medical services, including an MRI of the lumbar region, if such was performed, until December 28, 1991, the date of claimant's examination with Dr. Elmgren, are compensable as diagnostic services.

Finally, we conclude that claimant's December 28, 1991 visit with Dr. Elmgren is compensable since the examination was performed to determine the causal relationship between the back injury and claimant's impotence and incontinence. (Ex. 125A). However, since Dr. Elmgren concluded that the impotence was due to a "vasculogenic etiology," rather than the back injury, (*id.*), we further find that any further services performed after that date are not compensable as diagnostic services.

Offset

We affirm and adopt that portion of the Referee's order authorizing the insurer to offset temporary total disability benefits paid between June and September 1988 and March 1989 and January 1990 against any future awards of permanent disability.

Attorney Fees

Claimant's attorney is entitled to an assessed fee for prevailing in partially overturning the insurer's denial of diagnostic services. See ORS 656.386(1). After considering the factors set forth in OAR 436-15-010(4) and applying them to this case, we find that a reasonable fee for services at hearing and on review is \$1,800, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the 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 January 3, 1991 is modified in part and affirmed in part. That portion of the order finding that medical services rendered after June 28, 1990 were not compensable as diagnostic services is modified. A portion of the medical services after that date are compensable as provided by this order. The remainder of the order is affirmed. For services at hearing and on Board review regarding the diagnostic services issue, claimant's attorney is awarded \$1,800, to be paid by the insurer.

In the Matter of the Compensation of
ELLEN S. BUNTON, Claimant
WCB Case No. 91-10634
ORDER ON REVIEW
Myrick, Seagraves et al., Claimant Attorneys
Tom Dzieman (Saif), Defense Attorney

Reviewed by Board Members Hooton and Kinsley.

Claimant requests review of Referee Brown's order that upheld the SAIF Corporation's denial of her low back injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant, 32 years old at hearing, worked as a certified nurse's aide (CNA) for the employer. Her employment required her, with the assistance of another aide, to transfer patients who were unable to walk from beds to wheelchairs. On May 28, 1991, about 15 minutes before the end of her shift, claimant was transferring a patient into a wheelchair with the help of another aide when the patient's weight shifted, claimant slipped, and she twisted her back. (Ex. 2A; tr. 11).

Claimant sought treatment the next day at an emergency room, at which time she complained of pain in the midback radiating into the low back and some intermittent numbness in her legs, greater on the left. (Ex. 2A). Dr. Procknow, the emergency room physician, found positive leg raising on the left and recommended bed rest for three days. He diagnosed an acute midback and lumbar muscle strain. (Exs. 1, 2 and 2A). Dr. Procknow and claimant filled out and signed a form 827 in which claimant stated that she "went to pick patient up out of bed & transfer to shower chair with the assistance of shower aide. As I turned with her I believe my footing slipped as her weight shifted and I twisted my back." (Ex. 1).

Claimant had previously arranged to take a leave of absence over the summer to care for her five small children, beginning either on June 1 or June 15, 1991. On May 30, 1991, claimant notified the employer that she was going to start her leave early because of her back. She asked whether she would still be able to return to work in September and the employer said yes. (Tr. 15 and 51).

On June 11, 1991, Dennis Wills, the employer's administrator, called claimant after receiving notice that claimant had filed a workers' compensation claim. (Ex. 3). Claimant told him that she had not filled out an accident report at the hospital, but had asked them to bill Medicaid. Mr. Wills told claimant that the insurance company (*i.e.*, SAIF) charged more than Medicaid, but that they would pay the emergency room bill and deny the claim. (Tr. 17 and 18).

SAIF denied the claim on June 13, 1991, on the basis that "there is insufficient evidence that your lumbar sprain is the result of either a work-related injury or disease." SAIF also agreed to pay the emergency room bill. (Ex. 4).

Claimant's back continued to hurt. At the suggestion of her welfare caseworker, she consulted Dr. Purtzer in mid-July 1991, who referred her to Dr. Renaud.

When claimant sought treatment with Dr. Renaud, she complained of pain in the lumbar region with occasional shooting pains down into the right lower extremity as far as her knee. Renaud found diminished sensation in the L5 dermatome, tenderness in the L5 spinous processes and low back paraspinous muscle, positive straight leg raising bilaterally, and some guarding of left lower extremity function secondary to pain. Renaud reported that claimant stated that when she was working at the employer transferring a patient she had had a sudden onset of pain in her back, but, because she didn't have any witnesses at the time, she did not report the incident to her employer, so it did not get reported as a work injury. She also stated that by the time she went back to work the next day she had so much pain going down into the right lower extremity that she went to the emergency room.

Claimant has a preexisting dessicated disc condition at T12-L1 and L5-S1. Claimant's lumbar strain has combined with the dessicated disc condition to cause lower extremity pain.

FINDINGS OF ULTIMATE FACT

The work incident on May 28, 1991 is a material contributing cause of her disability and need for treatment. The compensable injury is the major contributing cause of claimant's current disability and need for medical treatment.

CONCLUSIONS OF LAW AND OPINION

The issue is whether claimant's current back condition, diagnosed as a midback and lumbar strain superimposed on a dessicated disc condition at T12-L1 and L5-S1, arose out of and in the course of her employment.

The Referee found all witnesses to be credible. He nevertheless concluded that claimant failed to establish that she experienced an injury at work, based on her failure to fill out an incident report at the employer, her attempt to have the hospital bill Medicare for the incident, and her subsequent report of an on-the-job incident. He also concluded that claimant made a workers' compensation claim to establish an excuse for not working in order to claim welfare benefits during the summer.

Credibility

Claimant argues that we should accord the Referee's credibility findings great weight and reverse his conclusion that she did not experience an injury during her employment and was attempting to perpetrate a hoax on the workers' compensation system.

SAIF contends that claimant did not sustain a compensable injury during the course and scope of her employment because her account of the incident is not supported by the only witness to the incident, because she failed to report her injury immediately to the employer or to file a workers' compensation claim, and because she falsely testified that she had not had any prior back injuries on the job.

SAIF first contends that claimant's credibility is suspect because her account of the incident is not supported by the only witness to the incident. At hearing, claimant testified as follows. On occasion, she had experienced back pain at the end of a tiring day, but a hot shower and a good night's sleep would dissipate her symptoms. On the day in question, she and an aide had been showering patients, which required transferring them from a bed to a wheelchair. About half an hour before the end of the shift, claimant lost her footing and the patient's weight shifted. Claimant twisted her back while she and the aide pulled the patient into the chair. Claimant further testified that she said, "I think I hurt my back," and that the aide said, "Are you all right," and she replied, "I'll be fine." After the incident, claimant left the floor to complete her charting prior to going off duty a few minutes later. After claimant went home, she took aspirin, had a hot shower and went to bed early without doing any domestic chores that evening. By morning, her back hurt so badly that she had her husband take her to the emergency room.

The emergency room physician, Dr. Procknow, and claimant filled out a Form 827 in which she reported the incident as follows: I "went to pick patient up out of bed & transfer to shower chair with the assistance of shower aide. As I turned with her I believe my footing slipped as her weight shifted and I twisted my back." Procknow found positive leg raising on the left and recommended bed rest for three days. He diagnosed an acute midback and lumbar muscle strain.

At hearing, the aide who was present during the incident testified that, because five months had passed between the incident and the hearing, she did not remember the incident or remember claimant saying anything. She did testify that she and claimant had lifted that particular patient together.

The evidence indicates that the incident was relatively minor when it occurred and that it worsened over that night, causing claimant to seek medical attention the next day. Furthermore, the medical report and claimant's husband's testimony corroborate the circumstances of the incident and its aftermath. In addition, the medical evidence of a middle and low back strain is consistent with the incident as reported. We conclude that the witness's failure to remember a relatively minor incident

that occurred five months earlier is insufficient to undermine the evidence in support of claimant's assertion that the injury occurred in the manner she described.

SAIF next contends that claimant's credibility is suspect because she did not report the incident at work. We have established above that the incident was relatively minor. We find no lack of credibility from the mere fact that claimant did not fill out an incident form during the last few minutes of her shift. In addition, we infer from claimant's testimony regarding her call to the employer on May 30, 1991 (tr. 15, 16 and 17), that she was concerned about whether she would be able to return to her job after her leave of absence. In addition, claimant and the doctor filled out and signed a Form 827 which included claimant's statement of the circumstances of the accident. This is sufficient notice to the employer. ORS 656.265(2). Further notice by claimant directly to the employer is not required by law. The evidence taken as a whole indicates that she was reluctant to file a workers' compensation claim and was under the mistaken notion that she had to fill out an incident report at work in order to file a workers' compensation claim.

SAIF lastly contends that claimant's credibility is suspect because she falsely testified that she had not had any prior back injuries on the job. Claimant testified that she had gone home in the past with a sore back, but it had gone away and that she took a day off work on May 18, 1991 because she was exhausted, although she told the employer it was because her back bothered her. Although there is evidence that claimant's back was occasionally symptomatic, neither statement amounts to false testimony that she had not had any prior back injuries on the job.

We conclude that claimant experienced an injury at work as reported in her testimony and in Dr. Procknow's uncontradicted medical report that claimant hurt her back while transferring a patient with the help of another aide when the patient started to fall and claimant slipped and twisted her back.

Compensability

Claimant has established the compensability of a May 28, 1991 injurious event, by proving that that event was a material cause of her subsequent disability and need for medical treatment for her back. See ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). However, because Dr. Renaud, orthopedic surgeon, diagnosed claimant with a midback and lumbar strain that was superimposed on her preexisting middle and low back degenerative condition, we conclude that claimant has a preexisting middle and low back condition that combined with her compensable injury to cause her middle and low back disability and need for treatment. (See ex. 9, p. 20). Accordingly, claimant bears the additional burden of proving that her compensable injury is and remains the major contributing cause of the claimed disability and treatment. See ORS 656.005(7)(a)(B); Bahman M. Nazari, 43 Van Natta 2368 (1991).

Dr. Renaud opined that claimant's injury was the major contributing cause of claimant's disability and need for treatment from the time of her May 28, 1991 work injury through her ongoing treatment by him that began on August 2, 1991. (See ex. 9 at 9, 19 and 21). We, accordingly, find that claimant has carried her burden of proving that her compensable injury is and remains the major contributing cause of her disability and treatment.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is \$2,500, to be paid by the SAIF Corporation. 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 March 2, 1992 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant's counsel is awarded an assessed attorney fee of \$2,500, payable by the SAIF Corporation.

In the Matter of the Compensation of
SANDRA R. FARROW, Claimant
WCB Case No. 92-02370
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Moscato, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Hooton.

The self-insured employer requests review of Referee Davis' order which set aside claimant's aggravation claim for a bilateral carpal tunnel syndrome condition. On review, the issue is aggravation.

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

The Referee found that claimant had sustained an increased loss of use or function of her forearms since claim closure and that this worsened condition was established by medical evidence supported by objective findings. We agree.

On review, the employer first contends that claimant failed to establish a compensable aggravation because there is no evidence that her worsened condition resulted in a diminished earning capacity. However, claimant here alleges a worsening of a scheduled condition, not an unscheduled condition. Therefore, in order to establish a compensable aggravation of a scheduled condition, claimant need only show that she is more disabled, *i.e.*, has sustained an increased loss of use or function of that body part, either temporarily or permanently, since the last arrangement of compensation. See ORS 656.214(2), 656.273(1); International Paper Co. v. Turner, 304 Or 354 (1987), on rem 91 Or App 91 (1988); Andrew L. Watkins, 43 Van Natta 2615, 2617 (1991); Jeffrey D. Morgan, 43 Van Natta 2348, 2349 (1991). On this record, we agree with the Referee that claimant has carried her burden.

The employer next contends that, even if claimant has proven a compensable aggravation, the medical evidence establishes only a right and not a bilateral carpal tunnel condition. We disagree. Dr. Layman, claimant's current attending physician, opined in his April 17, 1992 report that claimant's clinical findings were consistent with bilateral carpal tunnel, "worse on the right than on the left." (Ex. 34-2). We find that Dr. Layman's persuasive opinion establishes a diagnosis of both a right and a left carpal tunnel condition resulting from claimant's original accepted injury. Consequently, we conclude that the Referee correctly ordered the employer to accept claimant's bilateral carpal tunnel syndrome as an aggravation of her compensable condition.

Because the employer initiated the request for review and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an assessed fee under ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, and considering claimant's motion for a specific assessed attorney fee, we find that a reasonable fee for claimant's counsel's services on review concerning the aggravation issue is \$700, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue, as represented by claimant's respondent's brief and motion, the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated May 29, 1992 is affirmed. Claimant's attorney is awarded an assessed fee of \$700 for services on Board review, to be paid by the self-insured employer.

In the Matter of the Compensation of
ROBERT F. CURTIS, Claimant
Own Motion No. 91-0724M
OWN MOTION ORDER ON RECONSIDERATION
Philip H. Garrow, Claimant Attorney
Williams, et al., Defense Attorneys

Claimant requests reconsideration of our November 10, 1992 Own Motion Order in which we concluded that he had not sustained a worsening of his compensable condition until after his aggravation rights had expired. Claimant contends that, since the proposed surgery was ultimately deemed reasonable and necessary, his claim should have been reopened as of the date Dr. Kendrick first requested the surgery. At that time, claimant's aggravation rights had not expired.

Claimant's arguments were adequately addressed in our prior Own Motion Order and Order on Review. Robert F. Curtis, 44 Van Natta 956, on recon 42 Van Natta 1118 (1992). In our Order on Review, we determined that claimant's aggravation claim included Dr. Kendrick's recommendation for surgery. We further concluded that, although claimant had timely filed an aggravation claim, he had not established a compensable worsening. We found that the requested surgery represented a change in treatment approach rather than a worsening of claimant's compensable condition. Id. at 958. The fact that the Director subsequently found that the requested surgery was a reasonable and necessary treatment does not change our prior conclusion that this requested surgery did not represent a worsening under ORS 656.273. Consequently, we adhere to our prior order.

Accordingly, we withdraw our November 10, 1992 order. On reconsideration, as supplemented herein, we adhere to our November 10, 1992 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RAY B. HAMPTON, Claimant
Own Motion No. 92-0649M
OWN MOTION ORDER
Emmons, et al., Claimant Attorneys
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 March 28, 1980. SAIF recommends that we authorize the payment of temporary disability compensation. In addition, SAIF requests that we pro-rate temporary disability compensation between the above-captioned claim and another SAIF claim that is currently in open status. SAIF also requests authorization for reimbursement from the Reopened Claims Reserve.

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. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-12-055.

SAIF requests that we pro-rate temporary disability compensation between the above-captioned claim and another SAIF claim that is currently in open status. However, we lack authority to do so.

However, when concurrent TTD is due the worker as a result of two or more claims, pro rata distribution of benefits is available through the Director in accordance with OAR 436-60-020(7) and (8).

SAIF also requests the Board to authorize reimbursement from the Reopened Claims Reserve pursuant to ORS 656.625(b). The Court of Appeals has held that the Board lacks the authority to grant or deny reimbursement from the Reserve. See SAIF v. Holmstrom, 113 Or App 242 (1992). Accordingly, we are unable to grant SAIF's request.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed \$1,050, payable by SAIF directly to claimant's attorney. See OAR 438-15-010(4); 438-15-080.

IT IS SO ORDERED.

December 8, 1992

Cite as 44 Van Natta 2414 (1992)

In the Matter of the Compensation of
MARY J. McFADDEN, Claimant
 WCB Case No. 92-00566
 ORDER ON REVIEW
 Coughlin, et al., Claimant Attorneys
 Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of that portion of Referee Peterson's order which directed it to pay claimant's scheduled permanent disability award at the rate of \$305 per degree. Claimant contends that we do not have jurisdiction to consider that issue because SAIF withdrew its request for review, then two days later sought to preserve the rate of scheduled permanent disability issue. On review, the issues are jurisdiction and rate of scheduled permanent disability. We reverse.

FINDINGS OF FACT

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

On June 10, 1992, SAIF filed a "Withdrawal of Request for Review." On June 12, 1992, prior to the issuance of an order dismissing SAIF's request for Board review, SAIF clarified its withdrawal, stating that it wished to preserve the rate of scheduled permanent disability issue. On June 17, 1992, claimant objected, arguing that SAIF should not be allowed to preserve the issue.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

We retain jurisdiction to consider requests for review until those requests have been dismissed via Board order. See Sharon E. Kelly (Vangorder), 39 Van Natta 467 (1987). Although a withdrawal of a request for review may initiate the dismissal process, it is the dismissal order which terminates our appellate review authority.

Here, prior to our taking any action on SAIF's withdrawal, SAIF explained that it wished to preserve the rate of scheduled permanent disability issue. In other words, rather than withdrawing its request for review, SAIF was specifying the issue to which it was objecting on review. Under such circumstances, we retain jurisdiction to proceed with our review.

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). Therefore, we reverse those portions of the Referee's order which directed SAIF to pay claimant's scheduled permanent disability award at a rate of \$305 per degree, as well as awarded an out-of-compensation attorney fee payable from this increased compensation.

ORDER

The Referee's order dated April 16, 1992 is reversed in part and affirmed in part. That portion of the order which directed the SAIF Corporation to pay claimant's scheduled permanent disability award at the rate of \$305 per degree and which awarded claimant an attorney fee out of that increased compensation, is reversed. The remainder of the order is affirmed.

December 8, 1992

Cite as 44 Van Natta 2415 (1992)

In the Matter of the Compensation of
KENNETH L. RAASCH, Claimant
WCB Case No. 91-14431
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerland.

Claimant requests review of Referee Thye's order that upheld the insurer's denial of claimant's right inguinal hernia 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

Claimant seeks compensation for treatment and temporary disability for a right inguinal hernia. The Referee concluded that the hernia was not materially related to his industrial injury and upheld the insurer's denial. We disagree and reverse.

Claimant suffered a compensable back injury in May 1991, while carrying a tub of dishes down the stairs. The insurer accepted the claim as a non disabling lumbar strain and provided benefits. In August 1991, claimant returned from a camping trip and noticed a small lump in his groin. By mid-September, the lump had expanded to approximately three times its original size and had become painful. Claimant came under the care of Dr. Berecz, a vascular surgeon, who performed surgery to correct an indirect right inguinal hernia.

Two expert opinions on medical causation were submitted in this case. Dr. Berecz opined that claimant most likely sustained the indirect hernia during his May 1991 compensable low back injury, but only became aware of the problem when his back pain subsided. Dr. Battalia, who reviewed claimant's medical records, expressed the opinion that the compensable low back strain was not a material contributing cause of the hernia. He relied on the fact that claimant had an indirect-type of inguinal hernia, which he considers primarily to be congenital in nature.

When medical experts disagree, we tend to give greater weight to the conclusions of the treating physician. Taylor v. SAIF, 75 Or App 583 (1985). In this case, claimant's treating physician, Dr. Berecz, has examined and treated claimant since his May 1991 compensable injury. Because of Berecz's greater opportunity to evaluate claimant's condition, we find his opinion more persuasive and, accordingly, give it the most weight. Somers v. SAIF, 77 Or App 259 (1986). For similar reasons, we give less weight to the opinion of Dr. Battalia, who did not examine claimant. Moreover, there is no medical evidence, other than Battalia's theory, that claimant had a preexisting hernia sac. Because Battalia spoke only in general terms and did not render an opinion specific to claimant's condition, we do not find his opinion persuasive. See Bill J. Goodrich, 43 Van Natta 984 (1991).

Based on Dr. Berecz's opinion, we find that claimant's indirect inguinal hernia is materially related to his May 1991 compensable low back strain. Accordingly, we conclude that the condition is compensable and set aside the insurer's denial. Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

Claimant is entitled to an assessed attorney fee for prevailing against the insurer's denial of compensation. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is \$4,000, 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 appellate briefs and the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 16, 1992 is reversed. The insurer's denial of claimant's right inguinal hernia claim is set aside and the claim remanded to the insurer for further processing according to law. For services at hearing and on Board review, claimant's attorney is awarded an assessed fee of \$4,000, to be paid by the insurer.

December 9, 1992

Cite as 44 Van Natta 2416 (1992)

In the Matter of the Compensation of
WARREN G. BASCOM, Claimant
 WCB Case No. 91-01237
 ORDER ON REVIEW
 Malagon, et al., Claimant Attorneys
 Charles Lundeen, Defense Attorney

Reviewed by Board Members Kinsley and Brazeau.

Claimant requests review of those portions of Referee McWilliam's order that: (1) affirmed a Director's Review and Order finding that claimant was not eligible for vocational assistance; (2) failed to award temporary total disability benefits based on overtime; and (3) failed to award an attorney fee at hearing for services regarding the proper rate of claimant's temporary total disability benefits. On review, the issues are claimant's eligibility for vocational assistance, rate of temporary total disability benefits, 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

Vocational Assistance

In the Review and Order, the Director found that claimant was in a temporary job at the time of injury and, therefore, computed his base wage under OAR 436-120-025(1)(b). (Ex. 36-4). Under that computation, claimant qualified for work within 20 percent of his average wage, thereby disqualifying

him from vocational assistance. See OAR 436-120-005(6)(a)(A). The Referee, applying ORS 656.283(2), found that the evidentiary record supported the Director's findings and, consequently, the Director did not abuse his discretion in determining that claimant was ineligible for vocational assistance. See ORS 656.283(2). Accordingly, the Referee did not disturb the Director's Review and Order.

Under ORS 656.283(2), a worker who is dissatisfied with his vocational assistance must first apply to the Director for administrative review before requesting a hearing. The statute further provides that 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."

Under ORS 656.283(2), the Referee determines the historical facts relevant to the dispute and then, on the basis of that record, makes ultimate findings of fact to determine whether the Director's order is subject to modification for any of the specific reasons provided in ORS 656.283(2). Lasley v. Ontario Rendering, 114 Or App 543, 547 (1992). On review, the Board reviews the record made by the Referee and may make findings of fact different from those made by the Referee. Id.

Claimant contends that the Referee "misunderstood the appropriate standard" for reviewing the Director's Review and Order in that she applied a "substantial evidence" test rather than ORS 656.283(2). Furthermore, claimant asserts that the Director's order is invalid under ORS 656.283(2)(a) and (c) because it violates a rule and was made upon unlawful procedure and that the Referee should have reviewed the order under those subsections rather than for abuse of discretion under subsection (d).

We disagree with claimant's characterization of the Referee's order regarding her review of the Director's order. It is evident that she applied ORS 656.283(2)(d), determining that the evidentiary record supported the Director's findings that claimant was a temporary employee and therefore ineligible for vocational assistance because he qualified for work within 20 percent of his average wage. See Lasley v. Ontario Rendering, supra.

Furthermore, we agree with the Referee's application of subsection (d), rather than subsections (a) and (c), in reviewing the Director's order for abuse of discretion. Claimant asserts that the Director's order violated a rule by applying OAR 436-120-025(1)(b) rather than OAR 436-120-005(6)(a) and (b). This assertion, however, is based on his disagreement with the Director's factual finding that claimant was a "temporary" employee. The Director's findings of fact are reviewed for abuse of discretion under ORS 656.283(2)(d). Richard A. Colclasure, 42 Van Natta 2454, 2456 n 1 (1990). Moreover, when review of the application of a statute or rule is contingent upon a factual finding, we first determine whether the finding of fact was an abuse of discretion. See id. Therefore, we proceed to review whether the record supports the Director's finding that claimant was a temporary employee.

Here, although the Referee and this Board could ultimately conclude, based on the record before us, that claimant was a full-time employee rather than a temporary one, we also find that the Director had evidence before him from which he could have reasonably concluded that claimant was only a temporary employee when he was injured. Therefore, we agree with the Referee that the Director did not abuse his discretion in finding that claimant was a temporary employee and we adopt that portion of her order. Accordingly, the Director did not violate a rule when he applied OAR 436-120-025(1)(b).

Claimant's assertion that the Director's order was made upon an unlawful procedure is based on testimony from Shirley Welding-Randall, an investigator for the Rehabilitation Review Section of the Department, who was assigned to review the facts of claimant's case for the Director's order. According to claimant, Welding-Randall's testimony indicated that claimant understood that he was a permanent or regular employee and the employer considered claimant to be a temporary employee. Claimant asserts

that, based on this conflict regarding claimant's classification, Welding-Randall should have continued her investigation until this issue was resolved.

We first note that ORS 656.283(2)(c) allows modification of the Director's decision if it "was made upon an unlawful procedure." (Emphasis added.) By including the term "unlawful", we find that the statute requires a finding that the procedure employed by the Director was contrary to law before the decision may be modified. See Surles v. Sweeney, 11 Or 21, 24 (1883). In that regard, we note that claimant has cited to ORS 656.012(2)(b) for the general premise that an objective of the Workers' Compensation Law is to provide a fair and just administrative system. However, claimant fails to cite any specific legal basis, such as a statute or administrative rule, as support for his assertion that the Director's investigation was unlawful. Moreover, our own review fails to disclose any law requiring the Director to conduct any particular kind of investigation in the face of conflicting information between claimant and the employer. Therefore, we find claimant's argument unpersuasive.

Finally, we note that claimant objects to our order in Richard A. Colclasure, *supra*, based on the dissent in that order. In particular, claimant relies on the dissent's argument that the order deprives claimants of full due process protection as required by Carr v. SAIF, 65 Or App 110 (1983). In rejecting claimant's contention, we rely on the reasoning provided by the majority in Colclasure.

Rate of Temporary Total Disability Benefits

Although the Referee considered whether or not claimant qualified as "regularly employed" or "on call" in the context of determining the proper rate of temporary total disability benefits, she failed to determine whether or not overtime hours should have been included in calculating the proper rate of temporary total disability benefits. Because that issue was raised by claimant in his request for hearing, at hearing, and on review, we proceed to address it.

OAR 436-60-025(5)(e) provides:

"Insurers shall consider overtime hours only when the worker worked overtime on a regular basis. Overtime hours shall be included in the computation at the overtime rate. * * * If overtime varies in hours worked per day or week, use the averaging method described in [OAR 436-60-025(5)(a)]. * * *"

Under this rule, a claimant works overtime "on a regular basis" if the worker frequently works overtime, as opposed to overtime that is sporadic. Guy M. Gabel, 42 Van Natta 2314, 2316 (1990).

Here, claimant worked at his job for only four days. However, on each of those days, claimant worked overtime. Therefore, despite the short time that claimant worked, we conclude that he "frequently" worked overtime. He is, therefore, entitled to inclusion of such hours for purposes of calculating his temporary total disability benefits.

Finally, we note the apparent discrepancy in affirming the Referee's conclusions that, for purposes of vocational assistance, claimant was a temporary employee, but, for purposes of determining the proper rate of temporary total disability benefits, claimant was "regularly employed." We emphasize that this discrepancy is due to the different standard of review applied to review of the Director's order regarding vocational assistance, which is limited to abuse of discretion, in contrast to a preponderance of evidence standard of review to determine claimant's classification for temporary total disability benefits.

Claimant's counsel is entitled to an attorney fee of 25 percent, not to exceed \$3,800, of any increased compensation that may result once overtime hours are included in the computation of his temporary total disability benefits. See ORS 656.386(2); OAR 438-15-055(1).

Attorney Fees

Although the insurer did not file a written request for hearing, at the beginning of hearing, it raised a cross-issue contending that claimant had been paid an inappropriately high rate of benefits for temporary total disability and asked that the rate be reduced. (Tr. 5-6). Claimant asserts that he is

entitled to an attorney fee for successfully defending against the insurer's assertion of a cross-issue at hearing that the rate of claimant's temporary total disability should be reduced. We agree.

Under ORS 656.382(2), if the carrier files a request for hearing and the referee finds that the compensation awarded to a claimant should not be disallowed or reduced, the carrier is required to pay to claimant a reasonable attorney fee. An issue that is not formally raised by cross-request for hearing or review warrants an attorney fee under ORS 656.382(2) if it is treated as a cross-request and the claimant successfully defends against it. See Kordon v. Mercer Industries, 94 Or App 582, 584-85 (1989) (claimant was entitled to award of attorney fees under ORS 656.382(2) for prevailing against SAIF's request for reduction in his permanent partial disability award).

The insurer asserts that its cross-issue did not place at issue any factual or legal findings not already at issue by claimant's assertion that he was entitled to overtime in his temporary total disability. We disagree. Claimant's request for hearing asserted only that the rate of temporary total disability benefits should have included overtime. Overtime is included in the rate of temporary total disability benefits whether or not a worker is regularly employed or on-call. See OAR 436-60-025(5)(e). Had the Referee been limited to the overtime issue, therefore, she would have only needed to determine whether or not claimant "regularly worked" overtime. See id. However, because the insurer requested that the rate of claimant's temporary total disability be reduced, and that request was based on the insurer's assertion that claimant was a temporary employee, the Referee was required to determine whether or not claimant was a regular or temporary employee. Thus, the insurer's cross-issue placed at issue different factual and legal determinations than those placed at issue by claimant's request for hearing.

Moreover, by determining whether or not claimant was a regular or temporary employee, the Referee treated the cross-issue as a cross-request for hearing. By finding that claimant was a regular employee, the Referee did not reduce the rate of his temporary total disability. Thus, claimant successfully defended against the cross-issue. Under these circumstances, we find that claimant is entitled to a reasonable attorney fee under ORS 656.382(2). See Kordon v. Mercer Industries, 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 at hearing concerning the insurer's cross-request 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 the record), the complexity of the issue, and the value of the interest involved. We note that claimant's attorney is not entitled to an award for prevailing on the issue of entitlement to attorney fees at hearing. See e.g. Dotson v. Bohemia, Inc., 80 Or App 233, 236 (1986).

ORDER

The Referee's order dated August 7, 1991 is affirmed in part and modified in part. Claimant is entitled to inclusion of overtime hours in the calculation of his temporary total disability benefits. Claimant's attorney is awarded a fee of 25 percent, not to exceed \$3,800, of any increased temporary total disability benefits created by this order. Claimant's attorney also is awarded an insurer-paid fee of \$1,000 for services at hearing regarding the proper rate of temporary total disability. The remainder of the order is affirmed.

In the Matter of the Compensation of
EMMADENE A. MADRIGAL, Claimant
WCB Case No. 91-06652
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Bethlahmy's order which upheld the self-insured employer's denial of claimant's low back aggravation claim. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

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

We do not adopt the last sentence of the seventh full paragraph on page 2 of the Opinion and Order, nor do we adopt the last three paragraphs on the same page. Instead, we make the following findings.

Claimant's accepted condition has worsened since the date of the last arrangement of compensation, an Opinion and Order dated September 18, 1989.

There is no evidence that claimant's earning capacity has diminished as a result of her worsened condition.

CONCLUSIONS OF LAW AND OPINION

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).

Here, claimant's long-time treating physician, Dr. Eisendorf, examined claimant on January 21, 1991, documented her complaints of increased pain, and found increased tenderness over L1-2, L4-5 and the right sacroiliac joint, as well as markedly reduced range of motion in the lower back. (Ex. 39). He opined that claimant's symptoms represented an aggravation of her accepted low back condition. (Id.; see also Exs. 49, 50, 57, 58-4). He later explained that he was convinced that claimant was experiencing a markedly increased level of pain. (Ex. 60-8 to -9). After our review of the record, we find that Dr. Eisendorf's medical reports and opinions establish, with medical evidence supported by objective findings, that claimant experienced worsened symptoms due to her compensable low back condition beginning in January 1991.

However, we are unable to conclude from the record before us that claimant's worsened condition resulted in diminished earning capacity, as compared to September 1989, the date of the last arrangement of compensation. In September 1989, claimant remained released for modified work, although she had not worked since being laid off from a temporary job in November 1986. (See Exs. 33-13, 34). Dr. Eisendorf never indicated that claimant was less able to work in January 1991, as compared with September 1989, due to her worsened condition. Nor do we find any other medical evidence that indicates claimant was less able to work as a result of her worsened condition.

Claimant testified that she was more disabled in January 1991, as compared with September 1989, because she was in bed "a lot of the time" due to the severity of her pain. (Tr. 23). However, we do not consider claimant's testimony alone to be sufficient to establish that her worsened condition resulted in diminished earning capacity. See Patricia E. Cushman, 42 Van Natta 2360, 2361 (1990). Accordingly, we conclude that claimant failed to establish diminished earning capacity as a result of her worsened condition. Therefore, we find that claimant failed to establish an aggravation of her compensable low back condition in January 1991.

Because we find that claimant failed to establish a worsened condition which resulted in diminished earning capacity, we need not reach the question of whether her worsened condition was more than waxing and waning of symptoms contemplated by the previous permanent disability award. See ORS 656.273(8). Because we find that claimant did not establish a compensable aggravation, we need not reach the question of whether claimant was in the labor force at the time of the alleged aggravation, and therefore, we need not consider whether claimant made reasonable efforts to seek work prior to January 1991. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 257-58 (1989).

ORDER

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

December 9, 1992

Cite as 44 Van Natta 2421 (1992)

In the Matter of the Compensation of
IRENE P. THOMAS, Claimant
WCB Case No. 91-18169
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
David Lillig (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Hooton.

The SAIF Corporation requests review of Referee Crumme's order which set aside its denial of claimant's occupational disease claim for a myofascial pain condition. On review, the issue is compensability.

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

The Referee found that claimant's myofascial pain condition was established by medical evidence supported by objective findings. On review, SAIF contends that claimant's claim is not compensable because the medical evidence indicates that there were no objective findings and claimant's diagnosis is based solely on her subjective complaints of pain, which are not "objective findings" within the meaning the 1990 Workers' Compensation Law.

We agree with SAIF that in order to prove a compensable occupational disease, claimant must show that her claim is "established by medical evidence supported by objective findings." ORS 656.802(2). However, as noted by SAIF, we have previously stated in Suzanne Robertson, 43 Van Natta 1505 (1991), that a claimant may satisfy this statutory requirement 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. That determination need not be based solely on purely objective factors such as an x-ray that verifies the existence of a fracture. Instead, we have construed the "objective findings" requirement to be satisfied if the physician's evaluation of the physical condition is based only on the worker's description of pain and the physician's report indicates that she does, in fact, experience symptoms. Id. See Georgia-Pacific Corporation v. Ferrer, 114 Or App 471 (1992) (citing with approval our holding in Suzanne Robertson, supra).

Here, the Referee found that the reports of Dr. Gerry, claimant's treating physician, and Dr. Radecki, an independent medical examiner, constituted medical evidence supported by objective findings. In his report, Dr. Gerry examined claimant, noting diminished range of motion in all planes of claimant's neck and diagnosed myofascial pain condition. (Ex. 19). He prescribed physical therapy and medication. (Ex. 26). After examining claimant, Dr. Radecki also diagnosed myofascial pain condition. (Ex. 32-2). During the examination, he found tenderness in claimant's right sternocleidomastoid muscle, right and left trapezius, paraspinous muscles on the left occiput and the left levator scapulae insertion on the clavicle. (Id.). We find these reports sufficient to satisfy the "objective findings" requirement.

SAIF also argues that Dr. Radecki stated that there were no objective findings and that Dr. Gerry concurred with this assessment. However, Dr. Radecki went on to say in the same sentence that

claimant's diagnosis was based on her subjective history and her physical exam. (Ex. 32-3). Furthermore, as we stated in Craig H. Ayer, 43 Van Natta 2619 (1991), aff'd mem SAIF v. Ayer, 116 Or App 515 (1992), we do not find a physician's statement that there are no objective findings to be determinative. "Objective findings" is a legal term, not a medical term. Id. Moreover, the reports of Dr. Radecki and Dr. Gerry both indicate that there were objective findings. Accordingly, we conclude that claimant has established the compensability of her claim by medical evidence supported by objective findings. See Suzanne Robertson, supra.

Because SAIF initiated the request for review and we have not disallowed or reduced compensation awarded to claimant, claimant's counsel is entitled to an assessed fee under ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review of the compensability issue is \$250, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue, as represented by claimant's respondent's brief.

ORDER

The Referee's order dated April 20, 1992 is affirmed. For services rendered on review, claimant's counsel is awarded an assessed fee of \$250, to be paid by the SAIF Corporation.

December 10, 1992

Cite as 44 Van Natta 2422 (1992)

In the Matter of the Compensation of
DAVID D. DAVIS, Claimant
 WCB Case No. 91-15417
 ORDER ON REVIEW
 William H. Skalak, Claimant Attorneys
 Lundeen, et al., Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The insurer requests review of Referee Neal's order that set aside its denial of claimant's low back aggravation claim. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF OPINION AND LAW

The Referee concluded that claimant established a compensable aggravation of his low back. We agree.

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). To prove a worsened condition, claimant must show increased symptoms or a worsened underlying condition resulting in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 22 (1989) rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Further, the worsened condition must be established by medical evidence supported by objective findings.

Dr. Mack's chart notes and reports establish that claimant's low back condition had worsened following the July 1991 incident. This worsening is supported by Dr. Mack's objective findings of claimant exhibiting difficulty walking on his heels and toes, localized pain, and muscle spasms. Finally, Dr. Mack took claimant off work following the July 1991 incident, whereas at the time of the last arrangement of compensation (a July 1990 stipulation) claimant was released to work with no restrictions. Although a worker's absence from work does not create a presumption of a worsened condition, we find that the preponderance of the evidence establishes that claimant sustained a worsening of his low back condition that is supported by objective findings and resulted in diminished earning capacity.

Further, because claimant has previously been awarded unscheduled permanent disability, he must also show that the worsening is more than waxing and waning of symptoms contemplated by the previous permanent disability award. ORS 656.273(8).

Here, claimant's last arrangement of compensation was the July 1990 stipulation which awarded him 5 percent unscheduled permanent disability. The stipulation made no reference to the prognosis for claimant's low back condition. Moreover, there was no medical evidence at that time which indicated that claimant would have future periods of waxing and waning. Prior to that time, claimant was released to return to work with no restrictions. There is no medical opinion in the record which indicates that future waxing and waning was anticipated which would cause claimant to be disabled. We conclude, therefore, that claimant's last award of permanent disability did not contemplate future waxing and waning of his low back condition. See Lucas v. Clark, *supra*.

Finally, inasmuch as the July 1991 incident, which did not occur in the course and scope of his employment with the employer-at-injury, contributed to his worsened condition, he must also prove legal causation.

Subsequent to the Referee's order, we decided Roger D. Hart, 44 Van Natta 2189 (1992), in which we held that claimant has the burden of proving that the compensable injury is a material contributing cause of the worsened condition; however, pursuant to ORS 656.273(1), if the carrier denies the aggravation claim on the grounds that an off-the-job injury is the major contributing cause of the worsened condition, as the proponent of that fact, the carrier has the burden of proving it. Hart, *supra*.

Here, the only opinion regarding causation of claimant's low back condition is that of Dr. Mack. Dr. Mack noted that: "On 7/14, [claimant] was moving an oak door and somehow when he was packing the door, he twisted just right and got acute pain starting in his low back, particularly on the left. He has had this injury ever since 8/29/88." (Ex. 25). Dr. Mack reported at that time: "The old claim will have to be opened." (Id). Further, Dr. Mack, noting that he had treated claimant for his original injury in 1988, explained: "[Claimant] has had periodic troubles ever since that time and I feel that situation is just an extension of or exacerbation of the previous injury in 1988 and he really didn't suffer a new injury on July 14, 1991." (Ex. 30). Finally, Dr. Mack clarified that: "I really feel that [claimant's 1991 low back strain is] due to his previous injury because he has had recurrences off and on during the last several years." (Id).

After reviewing the record, we agree with the Referee that the medical evidence as reported by Dr. Mack supports claimant's burden of proof on causation. In particular, we note that Dr. Mack was aware of the 1991 incident and still did not alter his opinion that claimant's 1991 back condition was due to his original industrial injury. See Wanda N. Hainey, 44 Van Natta 674, 675 (1992). Further, Dr. Mack's opinion, although brief, explained how he was able to distinguish between the two potential causes of claimant's current condition. See Mary E. Shores, 44 Van Natta 901, 903 (1992). Finally, we find Dr. Mack's opinion persuasive as it is based upon his treatment of claimant both at the time of the original injury and the current exacerbation.

Under the circumstances, we conclude that Dr. Mack's report does not establish that an off-the-job injury is the major contributing cause of claimant's worsened condition. There is no evidence to the contrary. Accordingly, we conclude that claimant has established a compensable aggravation.

Inasmuch as the insurer 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 aggravation issue is \$950, 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 30, 1992 is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of \$950, to be paid by the insurer.

In the Matter of the Compensation of
CANDY M. KAYLER, Claimant
WCB Case No. 91-08225
ORDER ON REVIEW
Olson, et al., Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Hoguet's order that declined to award an assessed attorney fee pursuant to ORS 656.386(1) for allegedly prevailing over an aggravation denial. On review, the issue is attorney fees.

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

A June 11, 1991 Determination Order closed claimant's March 1991 right leg injury claim. Awarding approximately two months of temporary partial disability, the Determination Order found claimant's condition to be medically stationary as of May 10, 1991.

On June 18, 1991, the insurer issued a denial of claimant's aggravation claim. Noting that claimant's claim had been closed, the insurer contended that claimant's condition had not worsened since claim closure. On June 26, 1991, claimant, through her attorney, filed a hearing request regarding the insurer's denial. A hearing was scheduled for September 25, 1991.

On September 18, 1991, claimant, through her attorney, requested reconsideration of the Determination Order. In light of such circumstances, claimant's request for postponement of the scheduled hearing regarding the aggravation denial was granted.

On October 2, 1991, an Order on Reconsideration issued. Concluding that claimant's condition was not medically stationary at the time of the Determination Order, the Department set aside the closure order as premature. Finding that the claim remained in open status, the Department granted claimant's attorney a fee "equal to 10 percent of any additional temporary disability."

In light of the Order on Reconsideration, it was uncontested that the aggravation denial had been rendered moot. The only issue remaining for resolution was claimant's contention that her attorney was entitled to an attorney fee pursuant to ORS 656.386(1). In support of this position, claimant's attorney submitted a "Petition for Attorney Fees."

Asserting that she finally prevailed against the denial when it was rendered moot by the Order on Reconsideration, claimant sought a carrier-paid fee in addition to the out-of-compensation fee granted by the Order on Reconsideration. Noting the "out-of-compensation" attorney fee, the insurer contended that claimant's attorney was not entitled to an additional fee.

The Referee denied claimant's petition for an assessed fee, reasoning that the aggravation denial was rendered moot as a legal consequence of the Order on Reconsideration. Inasmuch as claimant had not prevailed against that denial as a result of any independent action by her attorney concerning that denial, the Referee concluded that claimant's attorney was not entitled to a carrier-paid fee under ORS 656.386(1).

We agree with the Referee's conclusion. We offer the following additional comments.

Subsequent to the Referee's order, we issued our decision in Mindi M. Miller, 44 Van Natta 1671, on recon, 44 Van Natta 2144 (1992). In Miller, an aggravation denial was rendered moot by a reclassification of the claimant's claim as disabling. We held that, even without a referee's declaration that the denial was a nullity, the denial had already been rendered null by operation of law. We concluded that the claimant did not require an order setting aside the denial to "set the record straight." Accordingly, we held that the claimant had not "prevailed" over a nullity and was not entitled to an assessed attorney fee under ORS 656.386(1).

We reached a similar conclusion in Jack J. Ford, Jr., 44 Van Natta 1493 (1992). In Ford, the claimant argued at hearing that his claim had been prematurely closed. As an alternative issue, he challenged the insurer's aggravation denial. The referee found the claim was prematurely closed and "set aside" the moot aggravation denial. On review, the claimant sought an attorney fee under ORS 656.386(1) for prevailing over the aggravation denial. We found that the referee's decision that the claim had been prematurely closed mooted the aggravation issue since there could be no aggravation while the claim was open. Based on this reasoning, we held that the claimant had not "prevailed" on his aggravation claim and we declined to award an assessed attorney fee pursuant to ORS 656.386(1).

In accordance with the Miller and Ford rationale, we reach the same conclusion here. Claimant did not "prevail" on her aggravation claim. That claim and the insurer's denial of it were rendered moot by operation of law when the Order on Reconsideration set aside the Determination Order as premature. There could be no valid aggravation denial while the claim was in open status, because there could be no valid aggravation claim. Therefore, a declaration by the Referee that the denial was void was unnecessary. It was equally unnecessary for the Referee to set aside the void denial. In short, claimant did not "prevail" on her aggravation claim and is, therefore, not entitled to an assessed attorney fee pursuant to ORS 656.386(1).

We have previously ruled that a claimant is statutorily entitled to an assessed attorney fee under ORS 656.386(1) for prevailing against a "void" aggravation denial. Carol J. Knapp, 41 Van Natta 855 (1989) (assessed fee not awarded because claimant's attorney did not file a statement of services). In a case on remand involving the same parties (reviewed in consolidation with the other Knapp order), we had directed the employer to process claimant's claim to closure. Carol J. Knapp, 41 Van Natta 851 (1989). In light of our decision in the case on remand, we reasoned that the employer's subsequent aggravation denial had been rendered moot because the claim had never been closed. Carol J. Knapp, 41 Van Natta at page 856. Since the employer had continued to contest the validity of its aggravation denial, we determined that the claimant had finally prevailed against a denial of compensation. Consequently, we held that the claimant was entitled to a carrier-paid attorney fee.

Here, unlike the employer in Knapp, the insurer did not seek to defend the validity of its denial. Rather, it was undisputed that the aggravation denial was mooted by the Order on Reconsideration. In these respects, therefore, this case is distinguishable from Knapp. Nonetheless, to the extent that Knapp and prior Board decisions can be interpreted to allow attorney fees pursuant to ORS 656.386(1) for prevailing over "void" or moot denials under the circumstances present in a case such as this, those decisions are disavowed.

Accordingly, based on the foregoing reasoning, we conclude that claimant is not entitled to an attorney fee pursuant to ORS 656.386(1) for "prevailing" over a void denial.

ORDER

The Referee's order dated April 15, 1992 is affirmed.

December 10, 1992

Cite as 44 Van Natta 2425 (1992)

In the Matter of the Compensation of
DARREL M. KIRK, Claimant
WCB Case No. 91-13956
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of that portion of Referee McWilliams' order that upheld the SAIF Corporation's denial insofar as it denied medical services and/or disability for claimant's current condition. In its brief, SAIF challenges that portion of the order that awarded an assessed attorney fee

for establishing compensability of the June 29, 1991 industrial injury. 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

Compensability

The Referee determined that claimant sustained a compensable right knee injury on June 29, 1991. She further concluded, however, that the compensable injury combined with a preexisting right knee condition and that claimant's resultant condition was not compensable, because the compensable injury was not the major contributing cause of his need for treatment and disability. After our review, we agree and adopt the Referee's conclusions and reasoning. ORS 656.005(7)(a)(B); Bahman M. Nazari, 43 Van Natta 2368 (1991).

Attorney Fees

The Referee also awarded claimant's counsel an assessed attorney fee under ORS 656.386(1) for prevailing, in part, against SAIF's denial of compensability. In its brief, SAIF contends that the award was in error and requests that the fee be reversed. Claimant responds that the award should be upheld and, in addition, requests an attorney fee under ORS 656.382(2) for successfully defending against a reduction of compensation. We disagree with each party's contentions and affirm.

ORS 656.386(1) provides, in part:

"* * * In such rejected cases where the claimant prevails finally in a hearing before the referee or in review by the board itself, then the referee or board shall allow a reasonable attorney fee."

ORS 656.382(2), provides, in part:

"If a request for [review] is initiated by an employer or insurer, and the [Board] finds that 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 * * * for legal representation by an attorney for the claimant[.]"

In this case, SAIF denied claimant's claim, in part, on the basis that claimant did not sustain an accidental injury arising out of and in the course of his employment. Because the Referee concluded that claimant had sustained a compensable injury, claimant "prevailed" on that issue and, consequently, is entitled to a reasonable attorney fee. See Greenslitt v. City of Lake Oswego, 305 Or 530 (1988). As a separate matter, however, claimant is not entitled to an attorney fee for defending against the attorney fee issue. Contrary to claimant's assertion, SAIF has not requested a reduction of "compensation" as that term is defined in ORS 656.382(2). Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated April 2, 1992 is affirmed.

In the Matter of the Compensation of
DONALD LATHROP, JR., Claimant
WCB Case No. 91-17109
ORDER ON REVIEW
Johnson, et al., Claimant Attorneys
Moscato, et al., Defense Attorneys

Reviewed by Board Members Moller and Brazeau.

Claimant requests review of that portion of Referee McWilliam's order that upheld the self-insured employer's denial of claimant's occupational disease claim for an insomnia condition. On review, claimant contends that his insomnia (and his resulting depression from that condition) are related to his rotating work schedule.

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

We agree with claimant that the record does not support the Referee's statement that Dr. Bond, Ph.D. and claimant's treating psychologist, had seen claimant on only three occasions. (See Ex. 5, Tr. 46-47). Nevertheless, for the other reasons cited by the Referee, we find that, despite Dr. Bond's status as the treating psychologist, her opinion that claimant's insomnia was caused by his rotating work schedule is overcome by that of Dr. Tearse, neurologist and sleep disorder specialist, who opined that claimant's insomnia was caused in major part by endogenous depression with some contribution from his work schedule, (Ex. 12-2, Tr. 69).

In particular, we find that Dr. Tearse's opinion is more persuasive based on his more extensive training in sleep disorders, as well as the fact that his opinion took into account that claimant had worked the same schedule for five years before he developed insomnia and his insomnia had not greatly decreased after stopping work. Dr. Bond, on the other hand, provided no explanation for the delay in onset.

Therefore, we agree with the Referee that claimant failed to prove the compensability of his occupational disease claim for insomnia. See ORS 656.802(1)(c). Inasmuch as claimant contends that his depression resulted from his insomnia, it follows that the depression is likewise not compensable.

Alternatively, claimant's contention could also be interpreted as a claim that his depression is compensable as a mental disorder. ORS 656.802(1)(b); 656.802(3). Were that his theory, we would continue to find the claim not compensable. Based on the persuasive opinion of Dr. Tearse, we would conclude that claimant has failed to establish by clear and convincing evidence that his depression arose out of his employment. ORS 656.802(3)(d).

ORDER

The Referee's order dated March 25, 1992 is affirmed.

In the Matter of the Compensation of
DOUGLAS G. REED, Claimant
WCB Case No. 92-01458
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

The self-insured employer requests review of that portion of Referee Gruber's order that directed it to pay claimant temporary total disability from January 27, 1992 through April 12, 1992. On review, the issue is entitlement to temporary disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Shortly after claimant was compensably injured, the employer informed him that he was fired. On December 23, 1991, claimant's attending physician approved a modified work position. Claimant was paid temporary total disability from the injury date through January 26, 1992. Temporary disability was terminated pursuant to a letter sent by the employer to claimant informing him of a modified position that had been approved by his attending physician and the job's effective date, and rate of pay. However, the letter also stated that because claimant had been terminated for good cause, he was not eligible to return to work.

The issue raised and litigated at hearing concerned only the employer's unilateral termination of temporary disability while the claim was in open status. It did not include temporary disability benefits awarded by an April 13, 1992 Notice of Closure. Thus, our review is limited to the issue of claimant's procedural, as opposed to substantive, entitlement to temporary disability. Therefore, we have original jurisdiction to address this matter. See Ralph E. Fritz, 44 Van Natta 1168 (1992).

The Referee found that the elements of ORS 656.268(3) were not satisfied and, therefore, the employer was not justified in terminating claimant's temporary disability benefits. The employer challenges this conclusion, asserting that it complied with all elements of ORS 656.268(3)(c) and ORS 656.325(5).

Under ORS 656.268(3)(c), temporary total disability may be terminated if the "attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment." We find that, in stating that modified employment must be "offered," the statute contemplates that the worker is available for such work. Furthermore, in stating that the worker must "fail to begin such employment," we find that the statute contemplates that it must be within the worker's discretion not to accept the employment.

Here, the employer did not "offer" modified employment to claimant, but merely informed him of a job that would have been available had he not been fired. Furthermore, claimant did not "fail" to begin the employment because, having been fired, he had no choice as to whether he would actually perform such work. Therefore, based on the plain language of the statute, we conclude that ORS 656.268(3)(c) was not satisfied and that the employer was not justified in unilaterally terminating payment of temporary disability.

The employer also relies on ORS 656.325(5), which provides:

"Notwithstanding ORS 656.268, an insurer or self-insured employer shall cease making payments pursuant to ORS 656.210 and shall commence making payment of such amounts as are due pursuant to ORS 656.212 when an injured worker refuses wage earning employment prior to claim determination and the worker's attending physician, after being notified by the employer of the specific duties to be performed by the injured worker, agrees that the injured worker is capable of performing the employment offered."

We construe the terms "offered" and "refuses wage earning employment" in the same way we have interpreted "offered" and "fails to begin [modified] employment" in ORS 656.268(3)(c). Therefore, we conclude that ORS 656.325(5) also was not satisfied because claimant was neither "offered" nor did he "refuse" wage earning employment.

Neither does OAR 436-60-030(5) support the employer's position, for it also requires that the injured worker refuse or fail to begin wage earning employment prior to claim determination and that the employer confirm an offer of employment in order for the carrier to cease payment of temporary total disability.

We also disagree with the employer that OAR 436-60-030(6)(b) supports its position. That rule provides that a carrier must continue payment of temporary partial disability until the "job no longer exists or the job offer is withdrawn," at which date the worker is again entitled to temporary total disability benefits. The rule also provides that "[d]ischarging the worker for violation of normal employment standards is not withdrawal of a job offer." Thus, termination is not a withdrawal of a job offer, and does not constitute grounds for termination of temporary partial disability.

Furthermore, we find that Darren C. Resch, 43 Van Natta 2272 (1991), cited by the employer, is distinguishable from this case. In Resch, the claimant was released to regular work, thus allowing for termination of total disability under ORS 656.268(3)(a). After the claimant returned to work, he was laid off for reasons not related to his employment. The Board found that "the insurer had no duty to recommence payment of temporary total disability benefits after claimant was laid off" because claimant's prior release continued in effect. Id. at 2273.

Here, because the provisions of ORS 656.268(3) were not satisfied, claimant's procedural entitlement to temporary total disability was never legally terminated. Furthermore, we question the employer's contention that, had it not discharged claimant until after he had accepted the modified employment, it would have been relieved of paying any temporary disability. See OAR 436-60-030(6)(b).

Finally, we note that a claimant's substantive entitlement to temporary total disability is determined at claim closure and is based on a showing that the claimant was disabled due to the compensable injury before being declared medically stationary. ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992). Therefore, the issue of whether claimant was not working because he had been discharged for reasons not related to his injury is relevant to claimant's disability before being declared medically stationary. Thus, that question is properly considered in determining substantive entitlement to temporary disability.

Claimant's attorney is entitled to an assessed attorney fee for prevailing against the insurer's request for review. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for services on review is \$800, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest to claimant.

ORDER

The Referee's order dated April 22, 1992 is affirmed. For services on review, claimant's attorney is awarded a reasonable fee of \$800, to be paid by the employer.

December 10, 1992

Cite as 44 Van Natta 2429 (1992)

In the Matter of the Compensation of
DONALD E. WOODMAN, Claimant
Own Motion No. 88-0110M
OWN MOTION ORDER
Bischoff & Strooband, Claimant Attorneys
Roberts, et al., Defense Attorneys

The self-insured employer has requested modification of the Board's April 8, 1988 order that granted claimant permanent total disability. The employer contends that the award should be rescinded on the basis that we lacked the authority to grant claimant permanent total disability. We decline to grant the employer's request.

FINDINGS OF FACT

In October 1974, claimant sustained a compensable injury to his left arm. In 1983, following expiration of claimant's aggravation rights, the employer voluntarily reopened claimant's claim for the payment of temporary total disability compensation.

In 1988, claimant's claim was submitted to the Board for closure pursuant to ORS 656.278. On April 8, 1988, the Board issued its Own Motion Determination which granted claimant temporary total disability benefits from August 22, 1983 through December 23, 1987. The order further granted claimant compensation for permanent total disability commencing December 24, 1987. The Board's April 8, 1988 order was not appealed.

CONCLUSIONS OF LAW AND OPINION

Contending that the Board lacked the authority to award claimant permanent total disability in 1988, the employer seeks rescission of that award. We are without authority to grant the employer's request.

Prior to January 1, 1988, the Board had the authority to modify, change or terminate former findings, orders or awards if in its opinion such action was justified. Former ORS 656.278(1). However, effective January 1, 1988, ORS 656.278(1) was amended to read:

"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 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." (Emphasis supplied).

The emphasized portion of ORS 656.278(1) clearly indicates that the Board's authority to modify, change or terminate former findings, orders or awards is limited to those situations set forth in subsection (a) or (b).

The Court addressed the Board's authority to grant permanent disability benefits, including permanent total disability, under the revised statute in Independent Paper Stock v. Wincer, 100 Or App 625, rev den 310 Or 195 (1990). In Wincer, the Board granted the claimant permanent total disability on the basis that the claim was in open status prior to January 1, 1988. The Court reversed the Board holding that amended ORS 656.278(1) abolished the Board's authority to award permanent disability benefits on own motion claims, effective January 1, 1988. Id.; see also State ex rel Borisoff v. Workers' Comp Board, 104 Or App 603 (1990).

The procedural history of a recent case provides further guidance regarding the Board's authority under amended ORS 656.278. See Arnold G. Wheeler, 44 Van Natta 1807 (1992) on recon 44 Van Natta 1866 (1992). In Wheeler, SAIF had petitioned the Board for reevaluation of claimant's permanent total disability award. We initially 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). 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 were persuaded by its initial decision regarding our authority to reevaluate awards of permanent disability for injuries pre-dating 1966. We concluded, 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. Arnold G. Wheeler, 44 Van Natta at 1808. However, as noted above, this authority is restricted to those situations where the compensable injury occurred prior to January 1, 1966. ORS 656.278(1)(b).

Here, the employer is asking that we modify an award pursuant to ORS 656.278(1). However, as noted above, our authority under ORS 656.278(1) is limited to those situations set forth in subsections (a) and (b). ORS 656.278(1)(a) is not applicable to this matter as it only authorizes the Board to grant temporary disability benefits. Claimant's compensable injury occurred subsequent to January 1, 1966, therefore ORS 656.278(1)(b) is not applicable. Given the clear language of ORS 656.278(1), we do not have the authority to grant the employer's request. Accordingly, the request is denied.

In reaching our conclusion we acknowledge that the award of permanent total disability in the instant case is not consistent with the court's holding in Wincer, supra. However, under ORS 656.278, the Board had the authority to make an inquiry and resolve the dispute. See SAIF v. Roles, 111 Or App 597 (1992). Therefore, if the Board's decision to grant permanent total disability was in error, the employer's remedy was to appeal our decision granting the award to the Court of Appeals. ORS 656.278(3). Since it chose not to do so, we are without statutory authority to provide that remedy at this time.

Claimant has requested an assessed attorney fee for services concerning the self-insured employer's request for reduction of his permanent total disability award. Entitlement to attorney fees in workers' compensation cases are governed by statute. Unless specifically authorized by statute, attorney fees cannot be awarded. Forney v. Western States Plywood, 297 Or 628 (1984). Here, although the employer's request initiated the dispute, it was not a request for review as that phrase is used in ORS 656.382(2). There is no other statutory authority that would allow an attorney fee in this instance. Accordingly, we are unable to award claimant's counsel an assessed attorney fee.

IT IS SO ORDERED.

December 11, 1992

Cite as 44 Van Natta 2431 (1992)

In the Matter of the Compensation of
BEVERLY A. HULSE, Claimant

WCB Case No. 92-00952

ORDER ON REVIEW

Garlock, Smith & Associates, Claimant Attorneys
Charles Lundeen, Defense Attorney

Reviewed by Board Members Brazeau and Kinsley.

The insurer requests review of Referee Schultz's order that: (1) found claimant's Request for Hearing was filed timely; and (2) increased claimant's unscheduled permanent disability award for a cervical/thoracic strain condition from 5 percent (16 degrees), as awarded by a Determination Order, to 15 percent (48 degrees). On review, the issues are timeliness of hearing request and extent of unscheduled permanent disability. We vacate.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of the first two full paragraphs on page 2, and with the following supplementation.

Claimant filed a Request for Reconsideration on which November 27, 1991 is recited as the date of mailing. A copy of this document was received by the insurer on November 26, 1991. (Ex. 28).

The Order on Reconsideration states that claimant requested reconsideration on December 18, 1991. The order issued on January 9, 1992. (Ex. 29).

Claimant filed a Request for Hearing on January 21, 1992.

At hearing, the insurer moved to dismiss, contending that claimant's request for hearing was received untimely.

Claimant's counsel opposed the motion and sought a continuance. The Referee granted an additional ten days for the parties to provide arguments on the timeliness issue as well as closing arguments on the extent issue.

FINDINGS OF ULTIMATE FACT

Claimant's Request for Hearing was received more than 180 days after the Determination Order issued.

CONCLUSIONS OF LAW AND OPINION

Timeliness

The insurer contends that, because claimant's January 21, 1992 Request for Hearing was untimely, the Hearings Division lacked subject matter jurisdiction over claimant's request. We do not agree that the Hearings Division lacked subject matter jurisdiction. Nevertheless, we vacate the Referee's order because we find claimant's hearing request to be untimely.

Subject matter jurisdiction depends on whether the tribunal has the authority to make an inquiry. It exists when a statute authorizes the tribunal to do something about the dispute. SAIF v. Roles, 111 Or App 597 (1992). The Hearings Division had authority under ORS 656.708 and ORS 656.704(3) to decide the issue in dispute. However, the request for hearing was subject to dismissal as untimely under ORS 656.268(6)(b). See Roles, supra.

The insurer raised the timeliness issue for the first time at hearing and moved to dismiss. Claimant moved for a continuance, which the Referee granted.

At hearing and on review, the insurer contended that December 18, 1991, the date recited on the Order on Reconsideration as the date the request for reconsideration was received, began the tolled period of reconsideration pursuant to ORS 656.268(6)(b). In its written closing argument, the insurer specified that November 27, 1991 was the date the reconsideration order was received. Claimant, relying on the insurer's recitation of the November 27, 1991 date of receipt, argued that the insurer had confused 160 days with the statutory 180 days and was therefore mistaken on the issue of untimeliness. Neither party provided any statutory or other authority on the matter.

When a claim is closed by a Determination Order, an objecting party must first request reconsideration of the order with the Department. ORS 656.268(5). ORS 656.268(6)(b) provides:

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

OAR 436-30-050(3) further provides:

"The time required to complete the reconsideration proceeding pursuant to this rule shall not be included in the 180 days from the mailing date of the Notice of Closure or Determination Order to request a hearing. The 180 day time limit will be tolled upon

receipt of the request for reconsideration until the date the reconsideration order is issued." (Emphasis added).

In addition, ORS 656.319(4) provides:

"With respect to objections to a reconsideration order under ORS 656.268, a hearing on such objections shall not be granted unless a request for hearing is filed within 180 days after the copies of the determination or notice of closure were mailed to the parties." (Emphasis added).

In this case, the Referee made the following finding of fact: "Claimant requested reconsideration on November 27, 1991 and a Reconsideration Order issued on January 9, 1992 affirming the Determination Order in all respects (Exs. 28, 29).¹" In footnote 1, on page 2 of his order, the Referee noted the following: "The Order on Reconsideration, Exhibit 29, states that claimant requested reconsideration on December 18, 1991. However, Exhibit 28, the actual request for reconsideration was mailed on November 27, 1991." The Referee tolled the period from November 27, 1991 to January 9, 1992 and concluded that claimant's Request for Hearing was timely. However, he provided no reasoning or conclusion of law he may have used to establish the date of mailing as the appropriate date from which to begin the tolled period.

ORS 656.268(5) provides no guidance in this matter, in that it does not specify the time when the statutory 180-day limit begins to toll. We thus rely on the Director's rule, OAR 436-30-050(3), set forth above, which establishes that the 180-day time limit will be tolled upon receipt of the request for reconsideration. The only document in the record that establishes the date the Director received claimant's Request for Reconsideration is Exhibit 29. We accordingly find that claimant's request for reconsideration was received on December 18, 1991.

In this case, therefore, we find that claimant filed his request for reconsideration on December 18, 1991, and the Department issued its order on January 9, 1992. The time from the June 25, 1991 Determination Order to the date the Appellate Unit received the request for reconsideration on December 18, 1991, was 174 days. This calculation was arrived at by excluding the date of the Determination Order and the date the request for reconsideration was received, in accordance with the last sentence of ORS 656.268(6)(b). Robert E. Payne, Sr., 44 Van Natta 895 (1992). Therefore, claimant had six more days after the January 9, 1992 Order on Reconsideration (the date of the Order on Reconsideration is also excluded), or until January 15, 1992, to file her request for hearing. Because claimant's request for hearing was not filed until January 21, 1992, the request was untimely. See ORS 656.319(4).

Accordingly, we vacate the Referee's order.

ORDER

The Referee's order dated May 5, 1992 is vacated. Claimant's request for hearing is dismissed as untimely.

December 11, 1992

Cite as 44 Van Natta 2433 (1992)

In the Matter of the Compensation of
FRANK E. LASSEN, Claimant
 WCB Case No. 91-13753
 ORDER ON REVIEW
 Bischoff & Strooband, Claimant Attorneys
 Allen Ludwick (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Brazeau.

The SAIF Corporation requests review of that portion of Referee McWilliams' order which assessed a penalty and separate penalty-related attorney fee for its allegedly unreasonable denial of

claimant's new occupational disease claim for a right elbow condition. On review, the issues are penalties and attorney fees. 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 SAIF's processing of a claim for right epicondylitis as an aggravation of a previously accepted claim for left epicondylitis, rather than as a new occupational disease claim, was unreasonable. The Referee, therefore, assessed a penalty equal to 25 percent of the amounts of compensation due at the time of the denial, payable to claimant. In addition, the Referee awarded an attorney fee in the amount of \$500 for claimant's attorney's efforts in recovering the penalty, payable by SAIF. We reverse the penalty and reduce the attorney fee.

Because 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, § 54; see Ida M. Walker, 43 Van Natta 1402 (1991).

Pursuant to ORS 656.262(10), claimant is entitled to a penalty if the carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." The penalty is assessed on amounts of compensation "then due." We agree with the Referee that SAIF's processing of claimant's claim as one for aggravation was unreasonable. However, we find no evidence in the record that there were any amounts of compensation due and owing at the time of hearing as a result of SAIF's claim processing. Absent such amounts, there is no basis for assessing a penalty. See Wacker Siltronic Corporation v. Satcher, 91 Or App 654, 658 (1988).

Nonetheless, claimant's attorney is entitled to an insurer-paid attorney fee under ORS 656.382(1) if the carrier unreasonably resists the payment of compensation. See Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

The Referee found, and we agree, that at the time of its denial on September 11, 1991 (Ex. 7), SAIF had no reasonable basis for denying a new occupational disease claim for right elbow epicondylitis, nor for processing the claim as an aggravation of a left elbow epicondylitis condition. We find that the physicians' opinions regarding claim administration are not probative on the medical question of whether a right elbow condition represents an aggravation of a nondisabling left elbow epicondylitis claim. (See Ex. 6-2, 6-6). SAIF accepted "epicondylitis left elbow" in 1989 (Ex. 4), and on that basis denied claimant's request for a splint for his right elbow (see Ex. 6-2), thereby necessitating this claim.

Under these circumstances, we find that SAIF's conduct inhibited the speedy, proper and fair resolution of this claim. It increased litigation and placed an unnecessarily greater burden on claimant to prove his claim. Additionally, SAIF's processing of the claim as an aggravation, if left unchallenged, would have effectively deprived claimant of a new five-year period of aggravation rights for a new occupational disease claim. See ORS 656.273(4). Thus, we conclude that SAIF unreasonably resisted the payment of compensation. See, e.g., Charles E. Condon, 44 Van Natta 726 (1992).

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 regarding the unreasonable claim processing issue is \$300, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record), the complexity of the issue, and the value of the interest involved. Consequently, we reduce the Referee's \$500 attorney fee award to \$300.

ORDER

The Referee's order dated March 26, 1992 is reversed in part, modified in part and affirmed in part. The Referee's penalty assessment is reversed. The Referee's \$500 assessed attorney fee award is reduced to \$300. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
TONY E. ALFANO, Claimant
Own Motion No. 87-0237M
OWN MOTION ORDER OF DISMISSAL
Royce, et al., Claimant Attorneys
Schwabe, et al., Defense Attorneys

Claimant requests review of the self-insured employer's October 6, 1992, Notice of Closure which closed his claim with an award of temporary disability compensation from April 2, 1987 through April 8, 1992. The employer declared claimant medically stationary as of April 8, 1992. Claimant contends that he is entitled to additional benefits as he is not medically stationary.

On June 30, 1987, the Board issued an Own Motion Order reopening claimant's claim for temporary total disability compensation and directing the employer to close the claim pursuant to ORS 656.278. However, we find that, under the facts presented in this case, the claim must be closed pursuant to ORS 656.268.

Claims which are reopened within the period for appealing from a Determination Order must be closed pursuant to ORS 656.268 rather than ORS 656.278. See ORS 656.268 and 656.278(2); Carter v. SAIF, 52 Or App 1027 (1981); Coombs v. SAIF, 39 Or App 293 (1979); Rosemary J. Harrell, 42 Van Natta 639 (1990).

Here, claimant's claim was last closed by a Determination Order dated October 8, 1986. Under former ORS 656.268(6), claimant had one year from the mailing date to request a hearing. However, claimant's claim was reopened under the Board's own motion authority on June 30, 1987, within the one-year period for appealing from the Determination Order. Thus, this claim must be closed under ORS 656.268 rather than ORS 656.278. Carter v. SAIF, *supra*; Coombs v. SAIF, *supra*; Rosemary J. Harrell, *supra*. Therefore, we set aside the Notice of Closure and remand claimant's claim to the employer for further processing to closure pursuant to ORS 656.268.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation, permanent disability compensation, or a combination of both, which results from this order, not to exceed \$1,050, payable by the employer directly to claimant's attorney. See OAR 438-15-010(4); 438-15-080.

IT IS SO ORDERED.

December 14, 1992

Cite as 44 Van Natta 2435 (1992)

In the Matter of the Compensation of
JAMES CANTON, Claimant
Own Motion No. 91-0626M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Roger D. Wallingford, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's October 14, 1992 Notice of Closure which closed his claim with an award of temporary disability compensation from November 6, 1991 through September 30, 1992. SAIF declared claimant medically stationary as of September 30, 1992. Claimant contends that he is entitled to additional benefits as he is not yet medically stationary.

An injured worker is considered medically stationary when no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). It is claimant's burden to establish that he was not medically stationary when the claim was closed. Berliner v. Weyerhaeuser, 54 Or App 624 (1981). Here, on September 23, 1992, Dr. North released claimant to his regular duties as of October 1, 1992 and opined that claimant could work for 4 hours a day. In addition, Dr. North also stated in his chart notes that same day, that claimant could be judged medically stationary as of the end of the month. We do not accept a projection of when a claimant might be

medically stationary unless a subsequent report confirms that claimant achieved medically stationary status as projected. Here, however, on October 9, 1992, Dr. North reiterated that claimant was medically stationary as of September 30, 1992 and that no further treatment was scheduled. Therefore, we find that claimant became medically stationary on September 30, 1992 and conclude that SAIF's closure was proper.

Accordingly, SAIF's October 14, 1992, Notice of Closure is affirmed in its entirety.

IT IS SO ORDERED.

December 14, 1992

Cite as 44 Van Natta 2436 (1992)

In the Matter of the Compensation of
NANCY K. DAWES, Claimant
WCB Case Nos. 91-05858 & 91-05931
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of Referee Hazelett's order that set aside its denial of claimant's right thumb condition. On review, the issues are scope of acceptance and compensability. We affirm.

FINDINGS OF FACT

Claimant, who is left handed, was employed as a full time cashier for the employer in July 1989. Operating the cash registers required claimant to use her right hand extensively. Claimant had no symptoms in her right hand prior to working for the employer.

In the summer of 1989, claimant began to notice symptoms of pain in her right hand. About two weeks after the onset of those symptoms, her right hand "locked up" and she sought treatment in the emergency room on August 12, 1989. Carpal tunnel or De Quervains were suspected and a wrist and thumb splint prescribed. Claimant filed a claim for pain in her right thumb, palm and arm. Under the section of the form asking for a description of the nature of the injury or disease, claimant wrote that she was not sure and had to see a specialist. She also included the tentative diagnoses of De Quervains and carpal tunnel. Although no formal notice of acceptance was mailed to claimant, the employer noted on the claim form that the claim was accepted as a nondisabling injury.

Claimant sought treatment from Dr. Gill in August 1989. Based on x-rays taken on August 12, 1989, Dr. Gill diagnosed degenerative change at the CMC joint of the thumb. Claimant missed no time from work and continued to perform her job using a plastic brace which immobilized her thumb.

On October 5, 1990, claimant again sought treatment from Dr. Gill. Dr. Gill noted that claimant had two separate problems. The first was the pain at the base of the right thumb with heavy pinch or grip. Dr. Gill felt that this was identical to the condition for which claimant was treated in August 1989. The second condition which had developed later was numbness, tingling and pain in the flexor surface of the right hand and wrist. A new claim was filed on October 5, 1990. The insurer denied the claim on December 12, 1990 stating that the condition was the responsibility of a prior claim filed in August 1989. (Ex. 16a).

On May 7, 1991, the insurer wrote to claimant stating in part:

"This is in regard to your above 'workers' compensation claim which was accepted on 9/14/89 as a non disabling claim. Your claim is now accepted as a disabling claim for right carpal tunnel compression. However, this will also serve to notify you that based on additional medical information that we have recently received, we are denying that the arthritic condition of your CMC thumb joint is a compensable work

related injury. We do not feel that your employment * * * is the major contributing cause of this condition. This is a back-up denial based on new and recent medical information we have received.

"Again please note this is only a partial denial. Your claim for right carpal tunnel remains accepted . . ."

Dr. Gill referred claimant to Dr. Nye and to Dr. Button for consultation. Claimant was also seen by Dr. Bachhuber.

CONCLUSIONS OF LAW AND OPINION

The Referee found that the May 7, 1991 letter from the insurer was a back-up denial of the right thumb condition. Accordingly, the Referee concluded that it was the insurer's burden to prove, by clear and convincing evidence, that the right thumb condition was not compensable and that the insurer had failed to meet this burden.

Scope of Acceptance

The insurer contends that it never officially or formally accepted the right thumb condition and that, consequently, its May 7, 1991 letter was not a back-up denial, but was a partial denial of the right thumb condition. We disagree.

Acceptance of a claim encompasses only those conditions specifically or officially accepted in writing. Johnson v. Spectra Physics, 303 Or 49 (1987). Whether an acceptance has occurred is a question of fact, to be decided on a case by case basis. SAIF v. Tull, 113 Or App 449 (1992).

Here, claimant filed a claim for pain in the hand, thumb and arm. The insurer checked the box on the 801 form indicating that the claim was accepted as a nondisabling injury. Dr. Gill subsequently diagnosed the condition claimant was suffering from in August 1989 as early degenerative change at the CMC joint of the thumb. In its May 7, 1991 letter, the insurer denied the right thumb condition characterizing its action as a back-up denial based on new medical information.

Although formal notice of acceptance was not mailed to claimant at the time the insurer checked the accepted box on the claim form, we find, based upon the evidence, that the insurer accepted claimant's claim for right hand, thumb and arm pain at that time. See SAIF v. Tull, supra.

We are persuaded that the insurer accepted the symptoms of the right thumb condition when it accepted the claim for a right hand, thumb and arm condition. See Georgia Pacific v. Piwowar, 305 Or 494 (1988). The record contains evidence that the symptoms of hand and thumb pain claimant suffered from in August 1989 were at least partially, if not completely, caused by the degenerative right thumb condition. In this regard, Dr. Gill indicated that the right thumb condition was the condition for which he treated claimant in August 1989 when the claim was filed. (Exs. 10; 24). Dr. Gill felt that the thumb condition was separate from the carpal tunnel condition which arose later.

Because we have concluded that the insurer accepted the right thumb condition, its May 7, 1991 denial constituted a back-up denial of that condition, and as a consequence, it must prove by clear and convincing evidence that that the claim is not compensable. ORS 656.262(6).

Back-up Denial

ORS 656.262(6) allows an insurer two years from its good faith acceptance of a claim in which to deny the claim if evidence is obtained which indicates that the claim is not compensable. If the worker requests a hearing on the denial, the insurer must prove by clear and convincing evidence that the claim is not compensable. Id. To be clear and convincing, evidence must establish that the truth of the asserted fact is "highly probable." Riley Hill General Contractor v. Tandy Corp., 303 Or 390, 402 (1987).

There are four medical opinions concerning the causation of the right thumb condition. Dr. Gill is the treating physician. He feels that the right thumb condition is an industrially related condition. Dr. Nye saw claimant in consultation. He opined that the degenerative right thumb condition was not

related to claimant's work. Dr. Button also saw claimant in consultation and opined that the degenerative process in claimant's thumb was idiopathic and that claimant's work activities were not the major contributing cause. Dr. Bachhuber also felt that the degenerative changes in the thumb were not related to work activities.

We normally give greater weight to the opinion of claimant's treating physician absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1984). Here, we find no persuasive reasons not to defer to Dr. Gill who has treated claimant's right thumb condition from the outset and is in the best position to render an opinion concerning its cause. In light of this persuasive opinion, we are not convinced that it is highly probable that the claim is not compensable.

Accordingly, the insurer has failed to prove by clear and convincing evidence that the claim is not compensable.

In the alternative, the insurer contends that claimant has not established a compensable occupational disease claim. We disagree. Assuming that the insurer did not accept the right thumb condition when it accepted the 1989 claim, we conclude that claimant has established that the thumb condition is compensable as an occupational disease. Claimant has the burden to prove that her employment conditions were the major contributing cause of the right thumb condition or its worsening. In addition, the existence of the disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings. ORS 656.802(2).

As we previously found, there are no persuasive reasons not to defer to Dr. Gill's opinion that the right thumb condition is related to her repetitive work activities. Accordingly, we would alternatively find that claimant has established that the right thumb condition is compensable as an occupational disease.

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 \$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 issues, and the value of the interest involved.

ORDER

The Referee's order dated March 23, 1992 is affirmed. For services on review, claimant's attorney is awarded \$800 payable by the insurer.

December 14, 1992

Cite as 44 Van Natta 2438 (1992)

In the Matter of the Compensation of
LYDIA L. KENT, Claimant
WCB Case No. 91-16337
ORDER ON REVIEW
Ackerman, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of Referee Livesley's order that: affirmed an Order on Reconsideration award of 17 percent (54.4 degrees) unscheduled permanent partial disability; (2) excluded certain medical evidence from Dr. Karasek, claimant's treating physician; and (3) assessed a penalty for the insurer's allegedly unreasonable delay in the payment of compensation. On review, the issues are extent of unscheduled permanent disability, admissibility of evidence, and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant, 44 years old at hearing, suffered injuries to her face, right shoulder and back in 1982 as the result of an off-the-job motorcycle accident. During that accident, she was thrown over the handlebars of her motorcycle and the motorcycle then landed on her back. She was diagnosed with a concussion, multiple facial and vertebral fractures, and a dislocated shoulder. Following that injury, she received chiropractic treatments on a regular basis to relieve chronic thoracic and lumbar pain. During the first seven months of 1990, she received 21 chiropractic treatments, during which time she frequently exhibited restricted ranges of motion of the lumbar spine and moderate to severe back pain.

On July 24, 1990, claimant began working for the insured as a certified nurse's aide. On August 2, 1990, she experienced increased low back pain while lifting a patient. An MRI scan revealed no evidence of disc herniation, and a myelogram of claimant's lumbar spine was interpreted as normal. The insurer accepted the claim as disabling and provided benefits.

Claimant came under the care of Dr. Karasek, M.D., who diagnosed a lumbar strain and reported that claimant's current back condition was unrelated to her prior motorcycle injury. He released her to sedentary work on November 21, 1990, but claimant was unable to perform the required duties and was referred for vocational assistance.

On February 1, 1991, Dr. Karasek reported that claimant was improving and that he expected claimant to become medically stationary with minimal residual in four weeks. On March 1, 1991, as expected, he declared claimant medically stationary with mild residual related to intermittent low back and right hip pain. He also reported that claimant's flexion, extension, rotation and lateral bending were within normal limits. The claim was closed by an April 16, 1991 Determination Order, which awarded no benefits for permanent disability. Claimant requested reconsideration by the Department.

Pursuant to claimant's request for reconsideration, the Department appointed a panel of medical arbiters, who examined claimant on October 28, 1991. The physicians noted that claimant demonstrated only 55 degrees of retained lumbar flexion and 15 degrees retained lumbar extension, but concluded that she showed "no sign of permanent partial disability." (Ex. 53-4).

On November 8, 1991, the Department issued its Order on Reconsideration, finding that claimant had suffered permanent disability as a result of her compensable injury and awarded claimant benefits for 17 percent unscheduled permanent partial disability. The insurer paid the permanent disability award on December 24, 1991, and requested a hearing on January 23, 1992.

CONCLUSIONS OF LAW AND OPINION

Extent of Permanent Disability

The primary issue in this case is the extent of claimant's permanent disability resulting from the compensable low back strain. The Referee found that claimant suffers permanent impairment as a result of the injury and, after determining the appropriate values assigned by the disability rating standards for claimant's age, education, adaptability and impairment, affirmed the award of benefits for 17 percent unscheduled disability.

The insurer raises several arguments on review, but we find that only one of them is essential to our determination of this issue. The disability rating standards provide that "[i]f there is no measurable impairment under these rules, no award of unscheduled permanent partial disability shall be allowed." OAR 436-35-270(2). After our review of the record, we agree with the insurer that claimant has failed to establish that she suffers permanent impairment due to her compensable low back strain.

Impairment is established by a preponderance of medical evidence based on objective findings. ORS 656.726(3)(f)(B). The only competent medical evidence in this case regarding that issue comes from Dr. Karasek, claimant's treating physician, and the panel of medical arbiters. ORS 656.245(3)(b)(B); ORS 656.268(7); Dennis E. Conner, 43 Van Natta 2799 (1992). On March 1, 1991, Dr. Karasek declared claimant medically stationary with mild residual related to intermittent low back and right hip pain. He also reported that claimant's flexion, extension, rotation and lateral bending were within normal limits.

When he submitted an 828 form a week later, he checked the box indicating that claimant had permanent impairment, explaining only: "See notes 3/1/91 Mild residual back pain." (Ex. 44). The medical arbiters, who examined claimant on October 28, 1991, noted that claimant complained of intermittent low back pain and reported that she had 55 degrees of retained lumbar flexion and 15 degrees retained lumbar extension. Nonetheless, they concluded that she has "no sign of permanent partial disability." (Ex. 53-4).

We find nothing from either Dr. Karasek or the medical arbiters to support a finding of rateable impairment. Pain is considered in the standards only to the extent it results in measurable impairment. OAR 436-35-320(2). While Dr. Karasek reported that claimant had intermittent low back and right hip pain, he failed to indicate whether it caused measurable impairment. To the contrary, he reported that her flexion, extension, rotation and lateral bending were within normal limits. While the medical arbiters indicated that claimant had some diminished range of motion upon examination, they evidently concluded that such findings did not reflect any corresponding permanent impairment caused by the August 2, 1990 compensable injury. See Suzanne Robertson, 43 Van Natta 1505, 1507 (1991). That conclusion is supported by the medical record, which reveals that claimant continued to seek treatment for back pain caused by a motorcycle accident up and until the day before the compensable injury, and that she frequently exhibited restricted range of motion during those treatments.

On this record, we conclude that claimant has failed to establish that she suffered permanent measurable impairment as a result of her compensable low back strain. Accordingly, we are precluded from awarding any benefits for unscheduled permanent partial disability. OAR 436-35-270(2); SAIF v. Bement, 109 Or App 387 (1991).

Evidentiary Matters

In its brief, the insurer contends that the Referee erred in excluding a report from Dr. Karasek, which was offered to clarify claimant's work release status at the time of closure. Because we have concluded that claimant has failed to establish entitlement to benefits for permanent disability, it follows that the insurer's argument is moot and requires no discussion.

Penalties

The Referee awarded claimant a penalty for the insurer's allegedly unreasonable failure to pay the permanent disability award within 30 days of the Department's Order on Reconsideration. Although we have since concluded that claimant was not entitled to an award of permanent disability, she was entitled to that award until it was overturned. Georgia-Pacific v. Piwovar, 305 Or 494 (1988). Therefore, we agree that penalties are appropriate, if the insurer's actions were unreasonable. ORS 656.262(10).

The insurer attempts to justify its failure to timely pay the award on the grounds that it had appealed the Order on Reconsideration. It relies on OAR 436-60-150(6)(c), which provides:

"Permanent disability benefits shall be paid no later than the 30th day after * * * [t]he date of any department order which orders payment of compensation for permanent partial disability, unless the order has been appealed by the insurer pursuant to ORS 656.313." (Emphasis supplied.)

We addressed a similar issue in Walden I. Beebe, 43 Van Natta 2430 (1991), in which we held that a carrier had not unreasonably resisted payment of temporary disability benefits pending its appeal of a referee's order. In that case, the claimant had argued that the carrier was obligated to pay temporary disability compensation due unless it requested Board review within 14 days of the referee's order. We disagreed, reasoning that a referee's order is not final if, at any time within 30 days from its issuance, a request for review is filed. Because the carrier had timely requested review, we concluded that the 14-day time limitation did not apply and, consequently, that the carrier had not unreasonably resisted the payment of compensation.

This case, however, involves the payment of compensation due under an Order on Reconsideration. The distinction is important, because the time limitation for appealing such an order

may approach 180 days. See ORS 656.268(6)(b). Thus, in an apparent effort to provide a fair and prompt system of delivery of financial benefits to injured workers, the Department has promulgated OAR 436-60-150(6)(c) to require payment of permanent disability benefits within 30 days after the Department's Order, unless the order has been appealed within that time. Here, there is no dispute that the insurer did not appeal the order until January 23, 1992, nearly two and a half months after the order was mailed. Accordingly, those benefits for permanent disability were "then due," upon which a penalty is appropriately assessed. ORS 656.262(10)(a).

The insurer also argues that its actions were reasonable, because there is no evidence that the Department actually mailed or that it actually received a copy of the Order on Reconsideration prior to its payment. We are unwilling to accept that speculative argument as a persuasive explanation for the insurer's otherwise unexplained delay in the payment of compensation. Accordingly, we agree with the Referee that the insurer's actions were unreasonable and, as supplemented herein, adopt his conclusions and reasoning. In reaching this conclusion, we note that claimant is not entitled to an attorney fee on review for defending against the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated March 20, 1992 is affirmed in part and reversed in part. That portion that affirmed the November 8, 1991 Order on Reconsideration is reversed. The April 26, 1991 Determination Order is affirmed in its entirety. The Referee's assessed attorney fee for prevailing against the insurer's request for a reduction of permanent partial disability is reversed. The remainder of the order is affirmed.

December 14, 1992

Cite as 44 Van Natta 2441 (1992)

In the Matter of the Compensation of
FRANK J. THORP, Claimant
WCB Case No. 91-13593
ORDER ON REVIEW
Royce, et al., Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Podnar's order that found that the Hearings Division lacked jurisdiction over the issues raised by claimant and denied all requested relief. On review, the issues are jurisdiction, extent of permanent disability, and attorney fees for an alleged failure to timely determine eligibility for vocational benefits. We conclude that we have jurisdiction and find that claimant is not entitled to an increased permanent disability award or an attorney fee.

FINDINGS OF FACT

In 1978, claimant suffered a compensable back injury while employed by a previous employer. Claimant received a total of 50 percent unscheduled permanent disability as a result of that injury.

Claimant began working for the employer in 1987. On June 9, 1989, he filed a claim with SAIF for a back injury and bilateral groin strain. (Ex. 1L). SAIF denied the claim on June 28, 1989. The denial was set aside and the claim found compensable as both an injury and an occupational disease by an Opinion and Order dated May 24, 1990. (Ex. 4).

The claim was closed by Determination Order dated March 22, 1991. (Ex. 19). The Determination Order stated: "Your previous disability and past receipt of money for such disability and the combined effects of your injuries have been considered in this award." The Determination Order awarded temporary disability only. Claimant requested reconsideration of the March 22, 1991 Determination Order.

On April 18, 1991, the Board issued an Order on Review which affirmed the May 24, 1990 Opinion and Order. However, the Board found that claimant's claim was compensable as an occupational disease only. (Ex. 22). SAIF appealed to the Court of Appeals. The parties stipulated that this matter would be remanded to the Board after the Court issued its decision in Aetna Casualty Co. v. Aschbacher, 107 Or App 494, rev den 312 Or 150 (1991).

On August 9, 1991 an Order on Reconsideration issued which affirmed the Determination Order in all respects. (Ex. 24). The Order on Reconsideration indicated that the effects of claimant's 1978 injury had been considered in determining the extent of permanent disability due to the 1989 claim.

On January 8, 1992, the Board issued an Order on Remand, Frank J. Thorp, 44 Van Natta 24 (1992), which found that claimant's occupational disease claim was not compensable and reinstated the insurer's denial.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The Referee noted that we had issued an Order on Remand which found that the underlying claim in this matter was not compensable. On this basis, the Referee concluded that he had no jurisdiction over the issues raised by this appeal.

Although we have found claimant's underlying claim noncompensable, we conclude that we have jurisdiction to address the issues raised by claimant. Pursuant to ORS 656.704(3) and 656.268(6)(b), the Board has the authority to make an inquiry and resolve this dispute. See SAIF v. Roles, 111 Or App 5917 (1992). Thus, the matters raised here are matters concerning a claim over which we have jurisdiction. Accordingly, we reinstate claimant's request for hearing and turn to the merits.

Permanent Disability

Claimant asserts that the Evaluation Division and the Appellate Unit improperly offset disability due to his 1978 injury from his disability due to the 1989 claim under former OAR 436-35-007(3). However, we have previously determined that claimant's claim is not compensable. Therefore, the law of the case is that claimant's condition is not compensable and there is no basis for any permanent disability award. Lloyd G. Crowley, 43 Van Natta 1416 (1991). Accordingly, claimant's contention that his 1978 disability award should not have been offset against his current claim has been rendered moot by the final determination that the current claim is not compensable. In other words, claimant is not entitled to permanent disability as a result of this noncompensable claim.

Attorney Fee

Claimant contends that he is entitled to an attorney fee pursuant to ORS 656.382(1) for SAIF's failure to timely determine his eligibility for vocational benefits during the pendency of the appeal of the underlying compensability case. We disagree.

Since the underlying claim is not compensable, there was no unreasonable resistance to the payment of compensation and, therefore, claimant is not entitled to an attorney fee pursuant to ORS 656.382(1). Boehr v. Mid Willamette Valley Food, 109 Or App 292 (1991); Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991). In any case, SAIF was under no obligation to pay for vocational services pending appeal of the compensability case. This is true under the law in effect both after July 1, 1990 and before July 1, 1990. See Richard A. Colclasure, 42 Van Natta 2574 (1990); amended ORS 656.313(1).

ORDER

The Referee's order dated January 9, 1992 is modified. Claimant's hearing request is reinstated. All requested relief is denied.

In the Matter of the Compensation of
ARTURO G. VASQUEZ, Claimant
WCB Case No. 91-17030
ORDER ON REVIEW
Gatti, et al, Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of that portion of Referee Brazeau's order that declined to award additional temporary disability. On review, the issue is temporary disability. We modify.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's reasoning and conclusions regarding the appropriateness of the insurer's termination of temporary total disability benefits as of October 26, 1991. ORS 656.268(3); ORS 656.325(5); OAR 436-60-030(5). As found by the Referee, as of that date claimant was entitled to temporary partial disability benefits at a rate of zero.

At hearing and on review, claimant argues that the temporary total disability benefits should have been reinstated once the employer notified claimant that the modified work was no longer available. We adopt the Referee's finding that the employer did not tell claimant that the modified work was not available as of October 27, 1991. However, it is undisputed that, when claimant subsequently inquired into the availability of the modified job, the employer told him on November 10, 1991 that the modified work offered was no longer available.

ORS 656.325(5) provides:

"Notwithstanding ORS 656.268, an insurer or self-insured employer shall cease making payments pursuant to ORS 656.210 [temporary total disability] and shall commence making payment of such amounts as are due pursuant to ORS 656.212 [temporary partial disability] when an injured worker refuses wage earning employment prior to claim determination and the worker's attending physician, after being notified by the employer of the specific duties to be performed by the injured worker, agrees that the injured worker is capable of performing the employment offered."

Thus, ORS 656.325(5) requires three elements before termination of temporary total benefits is allowed when a worker refuses employment: (1) agreement of the attending physician that the worker is capable of performing the job duties; (2) an employment offer; and (3) the worker's refusal to accept the employment offer.

An insurer may procedurally terminate temporary disability benefits without the claimant being medically stationary if any one of the conditions set forth in ORS 656.268(3) is met. Soledad Flores, 43 Van Natta 2504 (1991). ORS 656.268(3)(c) provides that temporary total disability benefits shall continue until "[t]he 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." Thus, ORS 656.268(3)(c) requires three elements similar to those required by ORS 656.325(5): (1) a written release from the attending physician for the modified employment; (2) a written offer of modified employment; and (3) the worker's failure to begin the modified employment.

We find that, in applying ORS 656.325(5) and ORS 656.268(3)(c), all three elements are required: the attending physician's approval, a job offer, and the worker's failure to accept or begin the job. Once one of the elements is withdrawn, the basis for termination of temporary total disability benefits pursuant to ORS 656.268(3)(c) and/or ORS 656.325(5) no longer exists. Therefore, temporary total

disability benefits must be reinstated, unless another provision of the law permits termination of the benefits.

In addition, OAR 436-60-030(5) and (6) apply ORS 656.268(3) and ORS 656.325(5). OAR 436-60-030(5) provides:

"An insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (1) when an injured worker refuses or fails to begin wage earning employment prior to claim determination, under the following conditions:

"(a) The attending physician has been notified by the employer or insurer of the physical tasks to be performed by the injured worker;

"(b) The attending physician agrees the employment appears to be within the worker's capabilities; and

"(c) The employer has confirmed the offer of employment in writing to the worker stating the beginning time, date and place; the duration of the job, if known; the wages; an accurate description of the physical requirements of the job and that the attending physician has found the job to be within the worker's capabilities."

OAR 436-60-030(6)(b) provides, in pertinent part:

"(6) Temporary partial disability compensation paid under section (5) shall continue until:

* * * *

"(b) The job no longer exists or the job offer is withdrawn. The worker is again entitled to temporary total disability compensation as of the date the job no longer is available. Discharging the worker for violation of normal employment standards is not withdrawal of a job offer[.]"

These rules clearly state that, whereas temporary total disability benefits may be terminated due to a worker's refusal of a job offer, those benefits must be reinstated if, on making a later inquiry into the availability of the position, the claimant is notified that the job no longer exists or the job offer is withdrawn. That is the case here.

Furthermore, our prior decisions support a holding that temporary total disability must be reinstated when an offer of modified employment is withdrawn. In Shirley I. Sanderson, 44 Van Natta 484 (1992), we found that the employer's inability to place the worker in other modified work, when the modified job offered by the employer was determined to be beyond the worker's physical limitations, represented a withdrawal of the offer of modified employment which triggered the duty to begin paying temporary total disability. In Kati A. Hanks, 44 Van Natta 881 (1992), we found that the employer's lock out effectively withdrew modified employment from the claimant and entitled her to temporary total disability benefits during the lock out. There, the claimant was unable to return to her regular employment for another employer because of the physical limitations due to her injury. Also, she was unable to voluntarily choose to participate in the formerly offered modified work because of the lock out; therefore, she was entitled to temporary total disability during the lock out. Kati A. Hanks, *supra* at 882. The same reasoning applies here, claimant is unable to return to his regular employment due to the physical limitations resulting from his physical injuries. Also, once the modified job offer was withdrawn, he could not voluntarily choose to perform that job.

Here, as found by the Referee, temporary total disability benefits were appropriately terminated on October 25, 1991 due to claimant's failure to begin the offered modified job. However, when claimant subsequently inquired into the availability of the offer, the modified job offer was withdrawn on November 10, 1991 when the employer told claimant that the work was no longer available because

of the upcoming, regular seasonal layoff. We find that the clear language of the cited statutes, rules, and cases required the insurer to reinstate temporary total disability once the modified job offer was withdrawn. We note that the seasonal nature of the job offer does not affect our decision. See International Paper Company v. Huntley, 106 Or App 107 (1991) (there is no statutory authority for terminating temporary disability benefits during a period in which a worker would have been seasonally laid off).

Accordingly, we conclude that the insurer was required to commence payment of temporary total disability benefits on November 10, 1991. Such benefits are to continue until such time that it is appropriate to terminate the benefits according to law.

ORDER

The Referee's order dated March 17, 1992 is modified in part and affirmed in part. Claimant is awarded temporary total disability benefits beginning November 10, 1991 and continuing until such benefits can be terminated or modified according to law. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed \$3,800. The remainder of the order is affirmed.

December 15, 1992

Cite as 44 Van Natta 2445 (1992)

In the Matter of the Compensation of
TINA R. FLANSBERG, Claimant
WCB Case Nos. 90-22505, 90-17315 & 90-15708
ORDER OF ABATEMENT
Martin J. McKeown, Claimant Attorney
Kevin Mannix, PC, Defense Attorneys
Beers, et al., Defense Attorneys
Garrett, et al., Defense Attorneys

Connecticut Indemnity Company requests reconsideration of our November 30, 1992 Order on Review which found it jointly responsible with Safeco Insurance Company and Liberty Northwest Insurance Corporation for claimant's bilateral carpal tunnel syndrome. Connecticut Indemnity contends that the last injurious exposure rule should be applied to relieve it of responsibility.

In order to further consider this matter, we withdraw our November 30, 1992 order. The other parties are granted an opportunity to respond to Connecticut Indemnity's motion. To be considered, these responses 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
JAMES E. CLINE, Claimant
WCB Case Nos. 91-07635 & 91-09432
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Charles A. Ringo, Defense Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

Liberty Northwest Insurance Corporation (Liberty) requests review of Referee Galton's order which: (1) declined to grant Liberty's motion to leave the record open to depose claimant's treating physician, Dr. Ordonez; (2) set aside its denials of claimant's aggravation claim for a neck condition; and (3) upheld Aetna Casualty Company's (Aetna) denial of claimant's "new injury" claim for the same condition. On review, the issues are the Referee's evidentiary ruling, compensability and responsibility. We affirm.

FINDINGS OF FACT

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

On May 18, 1991, Drs. Neufeld and Wilson of First Northwest Health reported that it was indeterminate whether the March 22, 1989 work injury with Liberty continued to be the major contributing cause of claimant's current worsened condition. On May 29, 1991, Dr. Neufeld further opined that claimant may have sustained a disc herniation at the time of his March 22, 1989 injury, and that the disc subsequently calcified. However, he could not comment with certainty. Dr. Neufeld concluded that the "only way of knowing for sure whether the current symptoms in claimant's neck and thoracic spine are related to the C5-6 interspace would be the patient's response to surgery." (Ex. 3).

Subsequently, Dr. Neufeld was informed that claimant had been involved in a March 1990 motor vehicle accident. Dr. Neufeld reported that he did not know how many times, or to what extent, claimant had been treated in that regard. Nevertheless, Dr. Neufeld indicated that claimant's injuries, i.e., the March 1990 motor vehicle accident and the March 1989 on-the-job incident, were "cumulative." Thereafter, Dr. Neufeld concluded that claimant's degenerative disc disease at C5-6 and need for surgery were not related to his on-the-job injury of March 22, 1989.

After reviewing claimant's CT and MRI scans and medical history, claimant's treating doctor, Dr. Ordonez, found claimant had a herniated disc and mild central disc bulge at C6-7. He also found large posterior osteophytes at C5-6 with consequential impingement on the thecal sac and apparent mild compression of the cord at that level. Dr. Ordonez attributed these findings to an old calcified herniated disc. On September 3, 1991, Dr. Ordonez opined that claimant's current condition was due to his original injury of March 1989, which never resolved and ultimately resulted in the need for surgery.

On September 18, 1991, Liberty received a copy of Dr. Ordonez's September 3, 1991 medical report from Aetna. (Ex. 46). The next day, Liberty attempted to arrange a conference with Dr. Ordonez. After being informed that Dr. Ordonez was unavailable, Liberty contacted Aetna on October 3, 1991. The first mutually available date for cross-examination of Dr. Ordonez was November 5, 1991.

On or about October 10, 1991, Liberty contacted the referee, inquiring as to how he would rule on a motion to leave the record open and continue the October 15, 1991 hearing for a post-hearing deposition of Dr. Ordonez. The Referee did not find that extraordinary circumstances existed which would justify a continuance. A few days later, the Portland Assistant Presiding Referee denied Liberty's motion to postpone the hearing.

CONCLUSIONS OF LAW AND OPINION

Remand

Liberty contends that the Referee erred in denying its motion to hold the record open for the purpose of deposing Dr. Ordonez. We review the Referee's ruling for abuse of discretion. James D.

Brusseau II, 43 Van Natta 541 (1991). After conducting our review, we conclude that the Referee did not abuse his discretion. He concluded that Liberty did not exercise due diligence to obtain the requested additional medical evidence. Neither did he conclude that extraordinary circumstances existed to justify Liberty's request for a continuance under OAR 438-06-091. We agree with the Referee's conclusion.

In the event that Liberty's contention constitutes a motion for remand, we reach the following conclusions: The Board 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 the material evidence was not obtainable with due diligence at the time of hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Bernard L. Osborn, 37 Van Natta 1054, 1055 (1985), aff'd mem 80 Or App 152 (1986).

For the reasons expressed in the Referee's order, we conclude that the evidence Liberty seeks to submit was obtainable at the time of hearing with the exercise of due diligence. Moreover, we are not persuaded that the record has been improperly, incompletely or otherwise insufficiently developed. Accordingly, the request for remand is denied.

Compensability/Responsibility

On March 22, 1989, claimant compensably injured his neck while working for Liberty's insured. That claim was closed by Determination Order on January 16, 1990, which awarded 7 percent unscheduled permanent disability for the cervical spine.

On March 18, 1990, claimant was involved in a "side-swipe" motor vehicle accident, which caused only temporary symptoms of neck pain, and dorsal and low back soreness. He received four chiropractic treatments and missed no time from work.

Claimant worked for Aetna's insured in January 1991. In February 1991, he suffered increased neck symptoms, for which he sought medical treatment. Following the identification of a herniated disc, claimant eventually required surgery.

The Referee found that neither an off-the-job injury or exposure, nor subsequent work at Aetna's insured, were the major contributing cause of claimant's worsened condition and the resultant need for curative treatment, including surgery, and time loss. He further concluded that claimant's original injury was the major contributing cause of his worsened condition. We agree.

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. Ruston, 44 Van Natta 124 (1992). We have previously determined that ORS 656.308(1) is applicable to occupational disease claims. See Donald C. Moon, 43 Van Natta 2595, 2596 n. 1 (1991).

In the present case, Liberty, as the last insurer against whom claimant had an accepted cervical strain injury, remains presumptively responsible. In order to avoid responsibility, Liberty has the burden of establishing that claimant's work activities for Aetna's insured were the major contributing cause of his worsened condition. See Rodney H. Gabel, 43 Van Natta 2662 (1991).

Where medical evidence is in conflict, we give greater weight to those opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). We also give greater weight to the opinion of claimant's treating doctor unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). In this case, we find no persuasive reasons not to defer to the well-reasoned opinion authored by claimant's treating physician.

Dr. Ordonez has been claimant's treating physician since March 1991. He found that claimant's compensable cervical strain injury never resolved following the 1989 injury. Further, after a review of claimant's record, Dr. Ordonez noted that while claimant was employed at Aetna's insured, he had experienced gradual increasing neck pain, but no new injuries to his neck, shoulders, back, or upper

extremities. Consequently, Dr. Ordonez concluded that claimant's current condition was due to his original injury of March 1989.

On the other hand, Dr. Neufeld, independent medical examiner, initially opined that "the only way of knowing for sure whether the current symptoms in [claimant's] neck and thoracic spine are related to the C5-6 interspace would be the patient's response to surgery." (Ex. 39-2). Subsequently, however, Dr. Neufeld altered his opinion. Since claimant had not informed him of the 1990 "side-swipe" motor vehicle accident, Dr. Neufeld speculated that claimant might not have been completely forthcoming in reporting his symptoms. (Ex. 47-1). Thus, Dr. Neufeld concluded that claimant's current neck condition and need for surgery was most likely not related to his on-the-job injury of March 22, 1989.

The record does not support a conclusion that the March 1990 "side swipe" motor vehicle accident had a lasting effect on claimant's neck complaints. In fact, the evidence establishes that claimant's symptoms, which required minimal chiropractic treatment, did not result in time loss or permanent impairment. (Tr. 80). In light of Dr. Neufeld's previous reliance on surgery findings regarding causation, we do not find his subsequent explanation for his changed opinion to be persuasive. In any event, we are persuaded by the opinion of Dr. Ordonez, claimant's treating physician.

Accordingly, we agree with the Referee's conclusion that claimant's initial injury remains the major contributing cause of his worsened condition and need for medical treatment. We also agree with the Referee's findings that claimant's subsequent work activities for Aetna's insured were not the major contributing cause of a worsening of his condition. Hence, responsibility remains with Liberty.

Inasmuch as Liberty has requested review and claimant's compensation has not been disallowed or reduced, claimant is entitled to a reasonable assessed attorney fee. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4), and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services on Board review is \$1,200, 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 issues, and the value of the interest involved.

ORDER

The Referee's order dated December 12, 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.

December 16, 1992

Cite as 44 Van Natta 2448 (1992)

In the Matter of the Compensation of
CLAUDIA D. GRAUNITZ, Deceased
WCB Case No. 91-17368
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

Claimant requests review of those portions of Referee Nichols' order that: (1) affirmed an Order on Reconsideration awarding scheduled permanent disability of 7 percent (10.5 degrees) for loss of use or function of claimant's left leg and 7 percent (10.5 degrees) for loss of use or function of claimant's right leg; (2) allowed an offset by the insurer; and (3) declined to award a penalty and attorney fee for an allegedly unreasonable failure to pay the scheduled disability award at the rate of \$305 per degree. On review, the issues are extent of scheduled permanent disability, offset, rate of scheduled permanent disability, and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINIONExtent of Scheduled Permanent Disability

We affirm and adopt that portion of the Referee's order regarding this issue.

Offset

A 1986 Determination Order awarded claimant 5 percent scheduled permanent disability for loss of use or function of her left leg. The Referee found that the insurer had properly offset the 7 percent scheduled permanent disability awarded by the Order on Reconsideration by the 5 percent awarded by the previous Determination Order. Claimant challenges this conclusion, asserting that, although the awards were for the same body part, they were based on different kinds of impairment and that "there is no reason to conclude" that claimant did not completely recover from her initial injury before sustaining an aggravation.

We first note that claimant primarily cites to ORS 656.222 and former OAR 436-35-007(3) (WCD Admin. Order 2-1991), which pertains to offsets pursuant to ORS 656.222. We agree with the Referee that, because ORS 656.222 applies only when a claimant sustains two separate injuries and claimant here experienced an aggravation, ORS 656.222 is not applicable. See City of Portland v. Duckett, 104 Or App 318 (1990).

Further, the record does not support a finding that claimant recovered from her initial injury. To the contrary, claimant's left leg complaints remained fairly consistent.

Moreover, we disagree that if a claimant's previous permanent disability award was based on different kinds of impairment from a current permanent disability award, then an offset should not be allowed. The previous Determination Order found that claimant's total scheduled permanent disability for her left leg was 5 percent. We have affirmed the Referee's conclusion that claimant's current scheduled permanent disability for her left leg totals 7 percent. If an offset was not allowed claimant would receive a total award of 12 percent scheduled permanent disability, a sum that is more than her current ratable disability for her left leg. Therefore, we conclude that, in order to maintain claimant's award at 7 percent, the insurer properly offset the prior 5 percent award against the current 7 percent award. See Milton Porter, Jr., 43 Van Natta 452 (1991).

Rate of Scheduled Permanent Disability and Penalties and Attorney Fees

Because we review the entire order, we reverse that portion of the Referee's order that directed the insurer to pay claimant's scheduled permanent disability award at the rate of \$305 per degree. Destael v. Nicolai Co., 80 Or App 596 (1986). Inasmuch as claimant was injured before May 7, 1990, she is entitled to be paid scheduled permanent disability at the rate in effect at the time of the compensable injury. ORS 656.202(2); former ORS 656.214(2). SAIF v. Herron, 114 Or App 64 (1992).

Having reversed this portion of the Referee's order, there is no entitlement to a penalty or assessed attorney fee based on the insurer's payment of the award at a different rate.

ORDER

The Referee's order dated April 3, 1992 is reversed in part and affirmed in part. That portion of the order that directed the insurer to pay claimant's scheduled permanent disability award at the rate of \$305 per degree and awarded an attorney fee payable from this increased compensation is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
JUDY A. JACOBSON, Claimant
WCB Case No. 91-16843
ORDER ON RECONSIDERATION
Goldberg & Mechanic, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

The insurer requests reconsideration of those portions of our December 1, 1992 Order on Review that awarded an assessed attorney fee of \$500 for prevailing against the insurer's request for review regarding extent of unscheduled permanent disability and awarded an out-of-compensation attorney fee of 25 percent of the increased unscheduled permanent disability benefits granted by the Referee and Board orders, not to exceed \$3,800.

A Determination Order first awarded claimant 27 percent unscheduled permanent disability. Claimant requested reconsideration. On reconsideration, the award was reduced to 10 percent. Claimant requested a hearing and the Referee increased his award to 17 percent. In its request for review, the insurer sought to reduce the award to 10 percent as granted by the Order on Reconsideration. On review, we found that claimant was entitled to a total award of 25 percent unscheduled permanent disability benefits. Our order also awarded a \$500 assessed attorney fee.

The insurer asserts that the "Board[,] instead of remanding, proceeded to rerate the matter of unscheduled disability in accord with claimant's cross-appeal of unscheduled disability and increased the award. Those circumstances should not result in an assessed fee against the carrier. Also the fee is excessive considering only two pages of [claimant's] Brief were devoted to this issue."

As explained by our order, the assessed fee was based on ORS 656.382(2), which provides that, if a request for review "is initiated by an employer or insurer, and the [] board * * * find[s] 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 [] board * * *." Pursuant to this statute, we properly based the assessed fee on the fact that the insurer requested review regarding the extent of unscheduled permanent disability and we found that this compensation should not be disallowed or reduced. Kordon v. Mercer Industries, 308 Or 290 (1989); Roger F. Slade, 43 Van Natta 631 (1991). Further, we conclude that, based on all the factors set forth in OAR 438-15-010(4), the award is reasonable.

Our order also awarded 25 percent of the increased unscheduled permanent disability award granted by the Referee and Board orders, not to exceed \$3,800. The insurer contends that, because it has already paid the 27 percent awarded by the Determination Order, the Board's order, having granted a 25 percent unscheduled permanent disability award, did not increase the amount already paid by the insurer and, therefore, provided no basis for awarding an attorney fee. The insurer requests that we clarify our order "to point out that no attorney fee is actually payable since there is no additional amount payable to claimant."

We agree that, because claimant has apparently been paid benefits exceeding those subsequently awarded by the Referee and the Board, claimant is not entitled to receive additional payment as a result of the orders. However, we do not agree that those orders did not award "increased" unscheduled permanent disability. Following the Order on Reconsideration, claimant was determined to have experienced a permanent loss of earning capacity equal to 10 percent unscheduled permanent disability. ORS 656.214(5). The Order on Reconsideration allowed the insurer to deduct benefits previously paid on the Determination Order against the 10 percent awarded on reconsideration. Because the Determination Order award exceeded the award on reconsideration, an overpayment existed. Nevertheless, as of the date of the reconsideration order, claimant's unscheduled permanent disability was determined to be 10 percent.

The Referee increased claimant's unscheduled permanent disability award to 17 percent and awarded an approved attorney fee out of claimant's increased compensation. On review, we increased claimant's unscheduled permanent disability an additional 8 percent, for a total award of 25 percent. The fact that the insurer was entitled to deduct the prior overpayment from the increased awards, so that no additional sums were due claimant, does not detract from the fact that both the Referee and the

Board awarded increased permanent disability. In this regard, the effect of the Referee's order and our order was to establish claimant's entitlement to unscheduled permanent disability of 25 percent, thereby reducing the insurer's existing overpayment to 2 percent and, correspondingly, limiting the insurer's ability to offset its overpayment against future benefits. See Anthony E. Cochrane, 42 Van Natta 1619 (1990), aff'd mem 108 Or App 191 (1991) (claimant entitled to out-of-compensation fee where, at hearing, counsel establishes substantive entitlement to temporary disability benefits previously paid during processing of claim).

Moreover, to adopt the insurer's argument would be to contravene the provisions of OAR 438-15-085(2). That rule states:

"An attorney fee which has been authorized under these rules to be paid out of increased compensation awarded by a referee, the Board or a court shall not be subject to any offset based upon a prior overpayment of compensation to the claimant."

Based on our conclusion that claimant's compensation was increased at hearing and further increased on Board review, claimant's attorney was entitled to a fee out of those increased benefits. OAR 438-15-040 & 438-15-055.

In reaching our conclusion, we distinguish the facts of this case from those before the Board in Ralph D. Stinson, Jr., 44 Van Natta 1274 (1992). In Stinson, the claimant first received an award of 8 percent permanent disability. On reconsideration, claimant's award was reduced to 3 percent. Following a hearing, claimant's award was subsequently increased to 15 percent. Claimant contended that he was entitled to an out-of-compensation attorney fee based on the increased compensation between the referee's 15 percent award and the 3 percent award on reconsideration. We disagreed. Instead, we awarded a fee based on the difference between the 8 percent Determination Order award and the 15 percent awarded by the Referee. In doing so, we relied on a prehearing stipulation between the parties to the effect that claimant was entitled to the 8 percent award made by Determination Order. Accordingly, claimant's compensation was increased by the referee from 8 percent to 15 percent.

Here, by contrast, no such stipulation exists. To the contrary, the insurer asserted at hearing and on review that the Order on Reconsideration award of 10 percent was correct and should be affirmed. Therefore, as we have previously concluded, claimant is entitled to a fee for increased compensation beyond the 10 percent awarded by the Order on Reconsideration. Consequently, the insurer is directed to pay the out-of-compensation attorney fees awarded by the Referee and Board orders.

Assuming that the permanent disability award granted by the Determination Order has been paid, as the insurer contends, our order will have created an overpayment of compensation, equal to the attorney fee awarded by the Referee and Board orders. Should those circumstances exist, the insurer is authorized to recover the overpayment created by the orders against claimant's future awards of permanent disability. See Kenneth V. Hambrick, 43 Van Natta 1287, 1288 (1991).

Accordingly, we withdraw our prior order. On reconsideration, as supplemented herein, we adhere to and republish our December 1, 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
KAREN T. MARIELS, Claimant
WCB Case No. 91-18352
ORDER ON REVIEW
Daniel Snyder, Claimant Attorney
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Moller.

The SAIF Corporation requests review of that portion of Referee Galton's order that directed it to pay claimant's scheduled disability award at the rate of \$305 per degree. Claimant cross-requests review of that portion of the order that affirmed an Order on Reconsideration finding claimant medically stationary on March 14, 1991. Submitting reports which pertain to her post-hearing surgery, claimant asks that we consider the reports or remand to the Referee. Inasmuch as we cannot consider any evidence which was not admitted at hearing, we treat claimant's request as a motion to remand to the Referee for the taking of additional evidence. See ORS 656.295(5); Judy A. Britton, 37 Van Natta 1262 (1985). On review, the issues are remand, rate of scheduled permanent disability and premature closure. We deny the motion to remand. The Referee's order is reversed in part and affirmed 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).

Premature Closure

The Order on Reconsideration affirmed a medically stationary date of March 14, 1991 set by the July 17, 1991 Determination Order. The Referee agreed that the medical evidence proved that claimant was medically stationary on that date and accordingly concluded that the claim was not prematurely closed. Claimant challenges this conclusion, asserting that, because her treating surgeons were suggesting another surgery, she demonstrated that she was not medically stationary.

Under ORS 656.268(1), claims shall not be closed if the worker's condition has not become medically stationary. "Medically stationary" means that "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). It is claimant's burden to show that she was not medically stationary on the date of closure. Berliner v. Weyerhaeuser, 54 Or App 624, 628 (1981). In determining whether claimant has carried this burden, we examine medical evidence available at the time of closure, as well as evidence thereafter, except that which pertains to changes in claimant's condition subsequent to closure. Scheuning v. J. R. Simplot & Company, 84 Or App 622, 625, rev den 303 Or 590 (1987).

In this case, Dr. Layman, hand surgeon and claimant's treating physician, performed a closing examination on April 12, 1991. He noted that claimant had also been examined by Dr. Nye, hand surgeon, who had recommended a second surgery that would resection the radial nerve and bury it in the muscle. (Ex. 3-4). Because claimant refused to undergo this surgery, Dr. Layman found claimant medically stationary. (*Id.*)

Dr. Nye later reported that claimant "would have been medically stationary on March 14, 1991, if she desired no further surgical intervention. If, on the other hand, [claimant] was willing to sacrifice the superficial branch of the radial nerve and the lateral antebrachial cutaneous nerve, then it would be my impression that she would have been able to be improved as far as her pain is concerned[.]" (Ex. 22-1). Dr. Nye further stated that the advised surgery was "dependent on whether or not [claimant] is willing to sacrifice complete loss of function in the superficial branch of the radial nerve and the lateral antebrachial cutaneous nerve to decrease the discomfort she is feeling in her wrist area." (*Id.*)

Finally, Dr. Layman stated in a March 1992 letter that he "meant to indicate in that closing report that [claimant] was considered medically stationary at that time because no further surgery was being considered by the patient. Since further surgery is being considered at this time by the patient, I feel that this should be considered something that may actually improve her final function in her forearm, and thus would indicate at this point that she is not medically stationary." (Ex. 26-1).

In those cases where a claimant's medically stationary status is contingent upon undergoing recommended surgery, we have held that a claim is not prematurely closed if the claimant refuses the surgery. *E.g.* Stephen L. Gilcher, 43 Van Natta 319, 320 (1991). Here, Dr. Layman and Dr. Nye indicated that if claimant decided not to have the forearm surgery, she was medically stationary. Because claimant, at the time of closure, refused the surgery, we conclude that she failed to prove that she was not medically stationary at that time. Furthermore, in light of our analysis above, we find that claimant's assertion that approval by a managed care organization of the surgery is an "admission" by SAIF that the claim was prematurely closed is without merit. Therefore, we conclude that the claim was not prematurely closed.

Finally, considering that our conclusion regarding the "premature closure" issue is dependent on claimant's refusal to undergo surgery at the time of claim closure, it follows that reports regarding post-hearing surgery (after she subsequently decided to proceed with the operation) are not relevant to our determination. In any event, we do not consider the present record (without the proffered reports) to be improperly, incompletely, or otherwise insufficiently developed. *See* ORS 656.295(5). Accordingly, we deny claimant's request to remand this case for the introduction of the post-hearing reports.

ORDER

The Referee's order dated May 14, 1992 is reversed in part and affirmed in part. That portion of the order directing SAIF to pay claimant's scheduled permanent disability award at \$305 per degree and awarding an attorney fee payable from this increased compensation is reversed. The remainder of the order is affirmed.

December 16, 1992

Cite as 44 Van Natta 2453 (1992)

In the Matter of the Compensation of
IOLA W. PAYNE-CARR, Claimant
 WCB Case Nos. 90-05670 & 91-09641
 ORDER OF ABATEMENT
 Peter O. Hansen, Claimant Attorney
 Roberts, et al., Defense Attorneys

On November 17, 1992, we affirmed a Referee's order which had affirmed a Director's order under ORS 656.327(2) finding that a proposed right knee surgery was not reasonable and necessary. Claimant has petitioned the Court of Appeals for judicial review of our order. Nevertheless, since the 30-day statutory period under ORS 656.295(8) has not expired, we retain authority to withdraw our November 17, 1992 order, notwithstanding claimant's appeal. *SAIF v. Fisher*, 100 Or App 288 (1990).

Consequently, on our own motion, we withdraw our November 17, 1992 order for further consideration. We shall proceed with our reconsideration of this case based on the arguments previously raised by the parties in their respective appellate briefs. After completing our further review of those arguments, we shall issue our order on reconsideration.

IT IS SO ORDERED.

December 16, 1992

Cite as 44 Van Natta 2454 (1992)

In the Matter of the Compensation of
FLORENCE L. SCOTT, Claimant
WCB Case No. 91-17703
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

The self-insured employer requests review of those portions of Referee Galton's order that: (1) set aside its partial denial of claimant's right radial nerve condition; and (2) set aside its denial of claimant's request for surgery. On review, the issues are compensability and medical services.

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

On review, the employer disagrees with the Referee's conclusion that neither Dr. Nathan nor Dr. Button are persuasive because they do not agree that claimant has two of the conditions that are compensable components of the claim. The employer argues that claimant's conditions were accepted by a claims examiner and do not constitute the law of the case because they have not been found compensable in a final order.

We do not agree that a claim must necessarily be litigated before compensability of a condition becomes the "law of the case." Here, the employer had conceded compensability of claimant's tendinitis and overuse conditions by accepting those conditions. Under the circumstances, we find Dr. Nathan and Dr. Button's subsequent contrary opinions to be irrelevant with regard to the issue of compensability. Furthermore, because the two doctors' opinions were based upon their shared belief that the original conditions were not compensable, we agree with the Referee that the persuasiveness of their opinions is diminished.

Claimant is entitled to an assessed attorney fee for prevailing over the employer's request for review. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is \$1,050, 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 and statement of services), the complexity of the issues and the value of the interest involved.

ORDER

The Referee's order dated March 18, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of \$1,050, to be paid by the self-insured employer.

In the Matter of the Compensation of
CLIFFORD A. BETTIN, Claimant
WCB Case No. 91-14934
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Kinsley and Hooton.

The self-insured employer requests, and claimant cross-requests, review of Referee Myers' order that: (1) modified a Determination Order to award additional temporary total disability (TTD) benefits; and (2) authorized an offset of overpaid TTD benefits against any future awards of permanent disability. On review, the issues are jurisdiction and claims processing. We affirm.

FINDINGS OF FACT

Claimant sustained a compensable low back injury on June 2, 1976. The claim was accepted, and later closed by Determination Order on June 14, 1979. Claimant's aggravation rights expired on June 14, 1984, and the claim was in "Own Motion" status thereafter.

By Own Motion Order dated March 31, 1987, the Board reopened the claim for the payment of temporary total disability (TTD) benefits as of September 19, 1985. Claimant was declared medically stationary as of February 13, 1989. The claim was closed by Own Motion Determination dated December 5, 1989, with an award of TTD benefits.

Sometime prior to the issuance of the Own Motion Determination, however, the employer found claimant to be eligible for vocational assistance and referred him for an authorized training plan (ATP). On claimant's request for reconsideration, the Board withdrew the Own Motion Determination. By Own Motion Determination on Reconsideration dated March 29, 1990, the Board declined to close the Own Motion claim, stating that claimant was entitled to TTD benefits during his participation in the ATP. The Board also directed that the claim be closed and reevaluated "pursuant to ORS 656.268(5)" when the training is completed.

In early March 1991, the Rehabilitation Review Section (RRS) of the Workers' Compensation Division (WCD) notified the employer that claimant was not eligible for vocational assistance and that the employer would not receive further reimbursement for expenses of claimant's vocational assistance. By letter dated March 14, 1991, claimant was notified that his vocational assistance was terminated. Claimant requested a Director's review of his eligibility for vocational assistance, but the termination of assistance was upheld.

On May 28, 1991, the employer issued a Notice of Closure, which purported to close the Own Motion claim with an award of TTD benefits. However, based on communications with the Board's Own Motion Specialist and WCD, the employer withdrew the Notice of Closure, reinstated TTD payments, and submitted the claim for closure by WCD.

On July 2, 1991, WCD issued a Determination Order which closed the claim with an award of TTD benefits from September 19, 1985 through February 13, 1989, and from September 5, 1989 through October 30, 1989. The order also found claimant to be medically stationary as of February 13, 1989. Claimant timely requested a hearing on the Determination Order, challenging the employer's processing of the claim and asserting entitlement to permanent disability benefits and additional TTD benefits.

CONCLUSIONS OF LAW AND OPINION

At hearing, the employer moved for dismissal of claimant's hearing request, asserting that the Referee lacked jurisdiction to review either the May 28, 1991 Notice of Closure or the July 2, 1991 Determination Order. The Referee denied the motion and modified the Determination Order to award TTD benefits from October 30, 1989 through March 14, 1991, on the basis that claimant was entitled to TTD benefits while engaged in training. The Referee also authorized the employer to offset TTD

benefits paid from March 15, 1991 through July 2, 1991 against any future awards of permanent disability.

On review, the employer reasserts its contention that the Referee lacked jurisdiction to modify the Determination Order. Specifically, the employer argues that, because claimant's claim was in Own Motion status, he did not have the right to appeal the Determination Order. We disagree.

It is undisputed that claimant's claim is in Own Motion status. Therefore, claimant is entitled to benefits to the extent and under the circumstances provided in ORS 656.278. ORS 656.278(4) provides that an employer "may voluntarily reopen any claim to provide benefits." Here, the employer determined claimant to be eligible for vocational assistance and referred him for training. Thus, although claimant was later determined not to be eligible for vocational assistance, we find that the employer voluntarily provided such benefits in accordance with ORS 656.278(4).

Former ORS 656.268(5)¹ provides, in relevant part:

"If * * * the worker becomes enrolled and actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726, * * * the worker shall receive temporary disability compensation while the worker is enrolled and actively engaged in the training. When the worker ceases to be enrolled and actively engaged in the training, the Department of Insurance and Finance shall redetermine the claim pursuant to subsection (4) of this section unless the worker's condition is not medically stationary." (Emphasis added.)

Claimant was referred for authorized training and actively engaged in such training pursuant to the Director's rules until his eligibility was terminated on March 14, 1991. (Ex. 2). Therefore, in accordance with former ORS 656.268(5), he was entitled to the payment of TTD benefits during his participation in training, even though he was later determined not to be eligible for such training. In Wayne D. Cooper, 38 Van Natta 913, 915 (1986), we held that a worker is entitled to TTD benefits while enrolled in authorized training, whether or not the worker has aggravation rights remaining.

We further conclude that when training was terminated on March 14, 1991, claimant was entitled to a redetermination of his claim pursuant to former ORS 656.268(4). The Department performed that redetermination and issued a Determination Order on July 2, 1991, which awarded TTD benefits. Upon issuance of a determination order, former ORS 656.268(6) provides that any party may request a hearing on that order within 180 days after the mailing date of the order. Claimant availed himself of that right and timely requested a hearing on the July 2, 1991 Determination Order. The fact that claimant's aggravation rights had expired did not preclude his right to the hearing. See Wayne D. Cooper, 39 Van Natta 325, 327 (1987).

Therefore, notwithstanding the fact that claimant's claim was in "Own Motion" status, once claimant entered authorized training, claimant was entitled to TTD benefits during training and a redetermination of his claim pursuant to former ORS 656.268(4), as well as the right to appeal that redetermination. Accordingly, we conclude that the Referee properly had jurisdiction to review the Determination Order. We also conclude that the Referee properly awarded additional TTD benefits through March 14, 1991, the date of termination of vocational training.

Finally, claimant contends on review that the July 2, 1991 Determination Order is invalid, because the Own Motion claim had already been closed by the employer's May 28, 1991 Notice of Closure. We disagree. After issuance of the closure notice, the employer sent a form 1503 (request for claim closure) to WCD and reinstated TTD payments. By taking those actions, the employer effectively withdrew its closure notice. Moreover, as we discussed above, claimant's enrollment and active participation in training entitled him to a redetermination of his claim pursuant to former ORS 656.268(4) and (5).

¹ Because claimant became medically stationary before July 1, 1990, the 1990 amendments to ORS 656.268 do not apply here. See Or Laws 1990 (Special Session), ch. 2, § 54(3).

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 \$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 claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated February 11, 1992 is affirmed. Claimant's attorney is awarded \$500 for services on Board review, to be paid by the self-insured employer.

December 17, 1992

Cite as 44 Van Natta 2457 (1992)

In the Matter of the Compensation of
TANYA A. CUBERO, Claimant
Own Motion No. 92-0648M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for her compensable injury. Claimant's aggravation rights expired on June 27, 1983. SAIF opposes the reopening of the claim on the ground that no inpatient surgery or hospitalization has been requested.

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.

Here, claimant underwent outpatient oral surgery for an abscess and fistula on a tooth which was injured in her 1976 injury. Thus, 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 she had outpatient surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-12-055.

IT IS SO ORDERED.

December 17, 1992

Cite as 44 Van Natta 2457 (1992)

In the Matter of the Compensation of
ALBERT THOMPSON, Claimant
Own Motion No. 89-0737M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Popick & Merkel, Claimant Attorneys
Schwabe, et al., Defense Attorneys
Beers, et al., Defense Attorneys

Claimant has requested reconsideration of the Board's November 18, 1992 Own Motion Order on Reconsideration in the above-captioned case. Claimant contends that he is entitled to additional temporary disability compensation because he is not medically stationary.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Evidence that was not available at the time of closure may be considered to the extent the evidence addresses the condition at the time of closure. Schuening v. J.R. Simplot & Co., 84 Or App 622, 625 (1987). Claimant bears the burden of proving that he was not medically stationary at the date of closure. Berliner v. Weyerhaeuser,

54 Or App 624 (1981). The resolution of the medically stationary date is primarily a medical question based on competent medical evidence. Harmon v. SAIF, 54 Or App 121 (1981).

Dr. Hoff, claimant's treating doctor, requested additional diagnostic testing that was performed on July 15, 1992. Claimant contends that the need for additional diagnostic testing demonstrates that he was not medically stationary when his claim was closed. We disagree. The need for additional diagnostic measures and palliative treatment does not preclude a medically stationary status. Linda F. Wright, 42 Van Natta 2570 (1990); Kenneth W. Meyers, 41 Van Natta 1375 (1989).

Furthermore, Dr. Hoff has not retracted his earlier opinion that claimant was medically stationary on June 15, 1992. In addition, nothing in the diagnostic test report submitted by claimant relates back to or discusses claimant's condition at the time of claim closure. Therefore, although claimant's condition may have required further diagnostic testing after his claim was closed, we do not consider that testing in our review of the claim closure. Scheuning v. I.R. Simplot & Co., *supra*.

Accordingly, our November 18, 1992 order is abated and withdrawn. As supplemented herein, we adhere to and republish our November 18, 1992 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

December 17, 1992

Cite as 44 Van Natta 2458 (1992)

In the Matter of the Compensation of
RODNEY L. WALKER, Claimant
WCB Case No. C2-02619
ORDER OF ABATEMENT
Baxter & Associates, Claimant Attorneys
Lundeen, et al., Defense Attorneys

On October 27, 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. As the disposition complied with statutory requirements and applicable administrative rules, we approved the agreement on November 30, 1992.

On December 9, 1992 the Board received the insurer's Motion to Reconsider and set aside the claims disposition agreement. It is the insurer's position that the agreement was drafted and issued in error, and that, pursuant to an approved Disputed Claim Settlement, the insurer has no accepted claim upon which to base such an agreement.

Pursuant to OAR 438-09-035, we may reconsider final orders under ORS 656.236, provided that the motion for reconsideration is filed within 10 days of mailing of the final order. Here, we find that the letter was filed with the Board within 10 days of mailing of our final order. Under the circumstances, we treat the letter as a request by the insurer that we reconsider our final order approving the claim disposition agreement.

In order to allow sufficient time to consider the motion, the above-referenced Board order is withdrawn and claimant is requested to submit his position regarding reconsideration within 14 days of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
CLIFTON EDWARDS, Claimant
WCB Case No. 91-18202
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Susan Ebner (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

The SAIF Corporation requests review of that portion of Referee Menashe'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

The Referee found that claimant, as a result of a September 20, 1991 work event, sustained a compression fracture and low back strain. SAIF first contends that claimant failed to prove that he suffered an injury at work on September 20, 1991 because his testimony regarding such an event was inconsistent with other testimony and documentary evidence and, therefore, should be rejected as not credible.

The Referee found claimant to be a "fully credible witness." Although it is not statutorily required, we generally defer to the Referee's determination of credibility. See Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). We do so in this case.

First, contrary to SAIF's contention, we find insufficient evidence disproving claimant's testimony that he reported the work injury to his supervisor. At most, SAIF showed that the employer's controller failed to receive a written report from claimant's supervisors concerning such an incident. (Tr. 42). That does not prove that claimant did not report the incident since the controller has no direct knowledge of whether or not an injury is reported. (Id. at 42-43).

We do agree that claimant's testimony was inconsistent with the history he gave to Dr. Jones, who was claimant's initial treating physician. Claimant told Dr. Jones that he was injured on August 30, 1991 while "picking up some things," (Ex. 8), which contradicts his testimony that he felt back pain on September 20, 1991 while bending over to glue together two pieces of pipe. However, in light of claimant's explanation that he gave the wrong date because he did not have his calendar showing his work schedule, (Tr. 14-15), we do not find such inconsistencies sufficient to overcome the Referee's credibility finding.

SAIF next challenges the Referee's conclusion that, although claimant was predisposed to sustaining a compression fracture due to cancer of the bone marrow which weakened claimant's bones, the preponderance of evidence established that the September 20, 1991 work event caused the compression fracture and, therefore, was compensable under ORS 656.005(7)(a). SAIF also objects to the Referee's finding that ORS 656.005(7)(a)(B) was not applicable.

There is no dispute that claimant has multiple myeloma, a form of cancer of the bone marrow, and that this disease preexisted the onset of claimant's back symptoms. With regard to the cause of claimant's back condition, the record contains opinions from Dr. Jones; Dr. Dobrow, hematologist and claimant's current treating physician; Dr. Mayhall, orthopedist; and Dr. Wilson, neurologist. Drs. Mayhall and Wilson conducted an independent medical examination. We first note that we give no weight to the opinion of Dr. Jones because he provides no indication that he is aware of claimant's diagnosis of multiple myeloma and, therefore, lacks a complete history. See Somers v. SAIF, 77 Or App 259 (1986).

A letter drafted by claimant's attorney to which Dr. Dobrow concurred stated that the multiple myeloma weakened claimant's bones, "such that it predisposed [claimant] to suffer bone injuries."

(Ex. 7-1). The letter further stated that claimant "suffered compression fractures in his lumbar spine as a result of his employment on September 20, 1991. While [claimant's] bone disease predisposed him to suffer these injuries, these compression fractures probably would not have occurred that day without the stresses caused by the physical nature of his work." (*Id.*)

Drs. Mayhall and Wilson reported that, if a work injury had occurred, "it may well be that it was a compression fracture. In that instance, it would still be our opinion that on a more probable than not basis this claimant's multiple myeloma had weakened his bones such that flexion activities would cause a compression fracture." (Ex. 9-6).

In Liberty Northwest Ins. Corp. v. Spurgeon, 109 Or App 566, 569 (1991), the Court of Appeals discussed when a claimant's idiopathic factors, as opposed to work activities, should be considered when deciding whether work is the major contributing cause of the claimant's occupational disease. The court found a:

"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. An employer is responsible for a disease that a claimant who has a particular susceptibility or predisposition develops due in major part to conditions at work. The predisposition to disease is not a bar to compensability, if work causes the disease. * * * If, in contrast, a claimant develops a disease in major part because of factors personal to her that are independent of any activities or exposures either off or on the job, the claim is not compensable, even if work contributed to some degree to causing the disease. All causes of a disease, as opposed merely to a susceptibility or predisposition, must be considered in determining which, if any, was the major contributing cause." *Id.* (Emphasis in original).

We do not construe the medical opinions as requiring the application of the Spurgeon analysis to this case. Although Dr. Dobrow uses the term "predisposition" when referring to claimant's multiple myeloma, we interpret the opinions of Dr. Dobrow and the independent medical examiners as agreeing that the multiple myeloma weakened claimant's bones, and that this weakened state, along with claimant's work activities, resulted in a compression fracture. Therefore, we find that the medical opinions indicate that claimant's work activities and preexisting multiple myeloma combined to cause the compression fracture, requiring the application of ORS 656.005(7)(a)(B).

When 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." ORS 656.005(7)(a)(B). 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.*

Having found no basis for overturning the Referee's finding regarding claimant's credibility, we accept his testimony that he suffered an industrial injury on September 20, 1991. Furthermore, the medical record supports the Referee's finding that this incident materially caused a compression fracture. (Exs. 7-1, 9-6). Therefore, we conclude that claimant proved a compensable injury.

Furthermore, we interpret Dr. Dobrow's opinion as providing that the compensable injury was the major contributing cause of claimant's compression fracture. Based on his opinion, we conclude that claimant satisfied ORS 656.005(7)(a)(B), therefore proving the compensability of his compression fracture. See Weiland v. SAIF, 64 Or App 810 (1983).

Alternatively, we conclude that, if claimant's multiple myeloma condition is an idiopathic or personal cause under Spurgeon and, therefore, not properly considered in determining compensability of the compression fracture, claimant has successfully proved compensability under ORS 656.005(7)(a) by showing that work activities were a material contributing cause of his need for treatment and disability

for that compression fracture. See John E. Perkins, 44 Van Natta 1020 (1992) (vasectomy found to be a predisposition to a congestive epididymitis condition).

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 \$1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest to claimant.

ORDER

The Referee's order dated April 10, 1992 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of \$1,000, to be paid by the SAIF Corporation.

December 18, 1992

Cite as 44 Van Natta 2461 (1992)

In the Matter of the Compensation of
TIM O. GRAYHAM, Claimant
 WCB Case No. 91-04586
 ORDER ON REVIEW
 Vick & Gutzler, Claimant Attorneys
 Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Kinsley, Brazeau and Hooton.

Claimant requests review of Referee Garaventa's order that upheld the SAIF Corporation's aggravation denial of claimant's claim for a left shoulder impingement syndrome condition. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

On February 26, 1990, claimant sustained a compensable left shoulder contusion while he was working for Norrell Services, Inc. He sought treatment from Dr. Roberts, who provided conservative treatment. The shoulder pain resolved after a short period of time, and Roberts released claimant to regular work in March 1990. SAIF accepted the claim for contusion of the left shoulder and processed it to closure with a May 9, 1990 Notice of Closure, which awarded no benefits for permanent disability.

In October 1990, claimant began working as a paper carrier for the Oregonian. The job required claimant to extend his left arm out the window of his car and throw papers over the car for approximately three and a half hours per day. After a few months, he began to experience occasional left shoulder pain. In March 1991, the pain had worsened to the point where claimant was unable to work. He returned to Roberts, who diagnosed shoulder impingement syndrome.

Claimant was examined by Dr. Zirschky on March 27, 1991. Zirschky diagnosed an impingement syndrome related to claimant's work delivering newspapers. He also identified claimant's anatomy, a significant hooking of the acromiion, and a deconditioned rotator cuff as predisposing factors. He believed that any contribution by the February 1990 injury was minor.

On April 2, 1991, SAIF denied claimant's claim for additional benefits, asserting that his left shoulder impingement syndrome was unrelated to the accepted shoulder contusion. Claimant timely requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's condition was not compensable, because he had failed to show that his February 1990 industrial injury was the major contributing cause of his disability and need for treatment. Although we agree with her ultimate conclusion, we offer the following analysis.

ORS 656.273(1) provides for additional benefits for worsened conditions resulting from a compensable injury:

"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."

As a general rule, a compensable aggravation is established by proof that the compensable injury is a material contributing cause of the worsened condition. Robert E. Leatherman, 43 Van Natta 1677 (1991). However, the worsening is not compensable if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment. Annette M. Cochran, 43 Van Natta 2628 (1991). An off-work injury may include an injury resulting from a discrete injurious event, as well as an injury caused by repetitive activities. Lucky L. Gay, 44 Van Natta 2172 (1992).

Evidence from three doctors was submitted in this matter. Dr. Zirschky, who examined claimant on March 27, 1991, opined that claimant's compensable shoulder contusion may have led to some scarring in his bursa and, therefore, was a possible minor contributing factor to his shoulder impingement syndrome. He concluded, however, that claimant's current condition was primarily caused by his repetitive throwing activities as a newspaper carrier. (Ex. 12).

In contrast, Dr. Roberts, the treating physician, characterized the compensable injury as the "primary index injury" leading to claimant's current complaints. (Ex. 15). Dr. Snider, who examined claimant on April 29, 1991, similarly attributed claimant's condition to the compensable injury, which he characterized as the "index incident." (Ex. 14A).

We find the opinion of Dr. Zirschky most persuasive. When there is a dispute between medical experts, we rely on those opinions that are well-reasoned and based on complete information. Somers v. SAIF, 86 Or App 259 (1986). We find only Dr. Zirschky's opinion meets those criteria. Dr. Snider's opinion was conclusory and not thoroughly explained. While Dr. Roberts appears to implicate the compensable injury, he agreed with Dr. Zirschky to the extent that claimant's work delivering newspapers clearly aggravated claimant's condition.

Based on Dr. Zirschky's opinion, we find that the major contributing cause of claimant's worsened condition was his independent work activities delivering newspapers. Accordingly, we conclude that claimant's worsened left shoulder condition is not compensable. ORS 656.273(1).

ORDER

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

Board member Hooton dissenting.

In examining the compensability of a claim for aggravation, the first issue is to determine whether the condition claimed is compensable. Thomas L. Fitzpatrick, 44 Van Natta 877 (1992). As the majority has noted, each of the physicians support some contribution from the original injury to the development of claimant's impingement syndrome. I would defer to the treating physician, who is in the position of having observed claimant from the time of the original injury to the onset of symptoms related to the impingement syndrome, to conclude that claimant has demonstrated, by the preponderance of the evidence, a material relationship to the injurious event.

The more significant issue arising in this case involves whether the insurer has borne its burden of proving that a subsequent injury, other than in the normal course of employment, is the major cause of the worsened condition. The resolution of that issue turns primarily upon whether claimant's employment-related activities over time in noncovered employment can be considered an injury under the statute. The Board recently resolved that question in Lucky L. Gay, 44 Van Natta 2172 (1992). I believe that the Board erred in its resolution of that issue, and extensively dissented. For the reasons cited in my dissent in Gay, I dissent in the present claim as well.

In the Matter of the Compensation of
DOROTHY M. HUFF, Claimant
WCB Case No. 90-20155
ORDER ON REVIEW (REMANDING)
Peter O. Hansen, Claimant Attorney
Kathryn Wilske (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Hooton.

Claimant requests review of Referee Neal's order that upheld the SAIF Corporation's denial of claimant's psychological condition. Claimant also moves to remand the case for the taking of additional evidence or, alternatively, to include the evidentiary documents in our review. On review, the issues are remand and compensability. We remand.

Claimant moves to remand the case for the taking of additional evidence or, alternatively, to include the evidentiary documents in our review. SAIF objects to the additional evidence on the basis that it was obtainable with due diligence and that it is relevant only to a worsening of claimant's condition, not to the compensability of her condition.

We first note that we have no authority to consider any evidence not already included in the record. Under ORS 656.295(5), we have authority to remand the case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See Bailey v. SAIF, 296 Or 41, 45 n. 3 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988) (approving applicability of Compton v. Weyerhaeuser Co., *supra*, to remand by the Board).

Here, the Referee found that claimant failed to prove the compensability of her psychological condition because she did not demonstrate sufficient dysfunction to establish that she had a neurotic depression. Claimant asserts that we should remand to consider medical and psychological reports that were generated after hearing, when claimant's suicidal tendencies resulted in a multidisciplinary evaluation after claimant had been brought to the hospital emergency room in the midst of a severe psychological crisis.

We find that there is a compelling reason to remand for admission of this additional evidence. The evidence concerns claimant's disability, was not obtainable at the time of hearing, and, because it goes directly to the existence of claimant's condition that was deemed noncompensable, it is reasonably likely to affect the outcome of the case. See Parmer v. Plaid Pantry #54, 76 Or App 405, 409 (1985). Therefore, we remand to the Referee for the admission of those reports proffered by claimant. In addition, the Referee shall allow SAIF an opportunity to cross-examine the authors of this additional evidence and present rebuttal evidence. The Referee shall conduct further proceedings in any manner that will achieve substantial justice. Thereafter, the Referee shall issue a final, appealable order.

ORDER

The Referee's order dated March 12, 1992 is vacated. This case is remanded to Referee Neal for further proceedings consistent with this order.

In the Matter of the Compensation of
DAVEY L. ODLE, Claimant
WCB Case No. 91-08211
ORDER ON REVIEW
Terry G. Sundkvist, Claimant Attorney
Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Moller and Hooton.

The SAIF Corporation requests review of Referee Podnar's order that: (1) refused to admit a transcript of a previous hearing; and (2) set aside its partial denial of claimant's psychological condition. 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

SAIF first objects to the Referee's refusal to admit Exhibit 16A, a transcript of a prior hearing, into evidence. SAIF argues that the Referee abused his discretion in failing to admit the document because the transcript was probative of SAIF's assertion that claimant lacked credibility and, because the issue of credibility was central to SAIF's defense, the Referee's ruling "resulted in unfair prejudice to SAIF." SAIF's argument, in large part, relies on ORS 40.170(1) of the Oregon Evidence Code and OAR 438-07-017.

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 with regard to the admissibility of evidence. See, e.g., Brown v. SAIF, 51 Or App 389, 394 (1981). Furthermore, OAR 438-07-017 provides that documents other than medical or vocational material pertaining to and created on or after the date of injury or exposure that are "reasonably believed relevant and material only for purposes of impeachment of a witness * * * may be offered and admitted solely for impeachment." Because the language of the rule is permissive, the Referee has discretion in deciding whether or not to admit evidence offered under this rule. See, e.g., Dean L. Watkins, 43 Van Natta 527, 529 (1991). Therefore, rather than determining whether or not the Referee's admission of the contested exhibit violated the Oregon Evidence Code, we review for abuse of discretion.

We find that the Referee did not abuse his discretion in ruling not to admit the hearing transcript. The prior proceeding concerned the issue of premature claim closure; as it does here, SAIF attempted to defend its position largely by characterizing claimant as lacking credibility and trustworthiness because, according to SAIF, claimant had "promoted his condition, by exaggeration, into an enormous amount of disability payments." Despite SAIF's contention, the Referee made no finding that claimant lacked credibility and that order was affirmed by the Board. We agree with claimant that, by seeking to admit the hearing transcript, SAIF was attempting to relitigate the issue of claimant's credibility at the prior proceeding. Under these circumstances, the Referee did not abuse his discretion in ruling not to admit the hearing transcript.

Compensability

We further find that the Referee correctly determined that claimant proved a compensable psychological condition. Because claimant contends that his psychological condition was caused by his compensable injury, the Referee correctly analyzed the claim under ORS 656.005(7)(a)(A), applying the major contributing cause standard. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

The record regarding causation consists of three opinions. Claimant's treating neurologist, Dr. Bell, informed SAIF on several occasions that claimant was suffering from depression. (Exs. 39, 41, 43, 48). Dr. Bell attributed claimant's psychological condition to claimant's back pain. (Ex. 50-2).

Dr. Parvaresh, psychiatrist, conducted an independent medical examination. Dr. Parvaresh found that those problems noted by Dr. Bell:

"are situational, related to what is going on in his life[.] * * * Besides, his make-up, his overall profile does not lend itself to a good outcome with psychotherapeutic intervention." (Ex. 25-6).

Dr. Parvaresh concluded that claimant had no:

"ongoing diagnosable psychiatric disorder, that he does get frustrated, angry and emotional when things are not going his way but these are not the kinds of problems that psychiatry can solve. * * * Finally, I do not believe this gentleman has any ongoing psychiatric impairment as a result of his industrial injury of June 10, 1988 since from what I gather from the last independent medical examination at Northwest Medical Consultants, they were not able to document any orthopedic residual from that injury." (Id. at 6-7).

Finally, claimant was evaluated by Dr. Lusky, clinical psychologist. Dr. Lusky diagnosed moderate to severe agitated depression. (Ex. 49). He reported that the condition was "brought on by a combination of factors. First, there is his obvious physical discomfort. This has been exacerbated by his anxiety related to the uncertainty of his status with the SAIF Corporation." (Id.).

We agree with the Referee that, based on the opinion of Dr. Lusky, claimant has carried his burden of proving that his psychological condition is a compensable consequence of his injury. Dr. Lusky's opinion is supported by Dr. Bell. Although Dr. Bell is not trained in psychological evaluation, his familiarity with claimant as the treating physician gives his opinion regarding claimant's emotional condition some reliability. Further, Dr. Parvaresh's opinion was based, in part, on his understanding that claimant suffered no residual symptoms from his compensable injury. That understanding is not supported by Dr. Bell or claimant's award of 32 percent unscheduled permanent disability. Therefore, we find that Dr. Lusky's opinion is entitled to more weight than that of Dr. Parvaresh. Consequently, we conclude that claimant proved that his compensable injury is the major contributing cause of his consequential psychological condition.

We reject SAIF's contention that claimant is not credible regarding his psychological condition because it proved that "claimant is willing to exaggerate and fabricate in order to manipulate the people and systems around him." With regard to claimant's psychological condition, the record is completely bare of any evidence indicating that claimant is fabricating or attempting to exaggerate his emotional symptoms. Therefore, on this record, we find no basis for finding that claimant lacks credibility regarding his psychological condition.

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

ORDER

The Referee's order dated October 8, 1991 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of \$1,200, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
DARIN H. RICHARDS, Claimant
WCB Case No. 91-17658
ORDER ON REVIEW
Rasmussen & Henry, Claimant Attorneys
Marcia Barton (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Michael Johnson's order that: (1) dismissed claimant's request for hearing; (2) found that an Order on Reconsideration was invalid because the reconsideration order issued without the appointment of a medical arbiter; and (3) found that jurisdiction over this matter remained with the Director. On review, the issue is the validity of the Workers' Compensation Division's (WCD) Order on Reconsideration.

We affirm and adopt with the following supplementation.

Claimant argues that, if the Board refuses to review the Order on Reconsideration, his appeal rights will expire before he is able to get a valid Order on Reconsideration. Thus, he argues, he will be without a remedy. We disagree.

As determined by the Referee, because the Order on Reconsideration is invalid, jurisdiction over this dispute has never left the Department. Olga I. Soto, 44 Van Natta 697 (1992), recon den 44 Van Natta 1609 (1992). Furthermore, ORS 656.268(6)(b) provides that the period of time from the request for reconsideration until the reconsideration is made is not counted in the 180 day period within which a party who objects to a reconsideration has to request a hearing. Here, since a valid reconsideration order has not issued and jurisdiction remains with the Department, it follows that the time period to request a hearing remains tolled. Thus, until the WCD issues a valid Order on Reconsideration, claimant's right to request a hearing appealing that order is protected pursuant to ORS 656.268(6)(b).

ORDER

The Referee's order dated April 28, 1992 is affirmed.

December 18, 1992

Cite as 44 Van Natta 2466 (1992)

In the Matter of the Compensation of
CHARLENE F. ROUNSAVILLE, Claimant
WCB Case No. 91-10674
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Gail Gage (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Howell's order which upheld the SAIF Corporation's partial denial of her medical services claim for a low back condition. On review, the issue is compensability.

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

The Referee concluded that claimant failed to prove that her current low back condition was a compensable consequence of her accepted varicose vein condition. We agree. The only two medical opinions addressing the relationship between claimant's low back condition and her varicose veins are the opposing opinions of Dr. Knox, claimant's treating physician, and Dr. Strukel, SAIF's medical advisor. When medical evidence is divided, we tend to give greater weight to the conclusions of the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983).

Here, we find persuasive reasons not to defer to Dr. Knox. Most recently, Dr. Knox opined that claimant's current low back condition was caused by an altered gait in her left leg, which in turn was caused by her 1978 "accident." (Ex. 83). Her 1978 "accident" was an aggravation of her varicose vein condition in her left leg caused by standing at work. (Ex. 5). However, since 1980, Dr. Knox has variously attributed claimant's left leg condition to noncompensable conditions (i.e., mononeuropathy involving the distal segments of the left peroneal nerve, mononeuropathy involving the left tibial nerve, and an old resolved L5-S1 radiculopathy). (Exs. 9, 46). While most recently he attributes claimant's left leg condition and resulting altered gait to her compensable varicose vein condition, he does not explain the reason for his changed opinion. (Ex. 50, 83). Consequently, we give his opinion reduced weight.

On the other hand, we do find the opinion of Dr. Strukel more persuasive in this regard. After a review of claimant's extensive medical record, he noted that only Dr. Knox and Dr. Tsai had found evidence of an altered gait and that there was no medical correlation between varicose veins and claimant's degenerative back condition. (Ex. 82). He opined that claimant's degenerative condition was the result of the natural aging process and was unrelated to her compensable varicose vein condition. (*Id.*). Accordingly, we conclude on this record that claimant has failed to establish the compensability of her claim.

ORDER

The Referee's order dated March 5, 1992 is affirmed.

December 18, 1992

Cite as 44 Van Natta 2467 (1992)

In the Matter of the Compensation of
STEVE WERNER, Claimant
WCB Case No. 91-11739
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Barber's order that dismissed his 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 January 24, 1991 Notice of Closure. We agree.

A request for hearing must be filed within 180 days after the date copies of the Notice of Closure are 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." (Emphasis added). See Steven E. Edgerly, 44 Van Natta 2148 (1992); Robert E. Payne, Sr., 44 Van Natta 895 (1992).

In this case, the self-insured employer mailed the Notice of Closure on January 24, 1991. The Department received claimant's request for reconsideration on July 18, 1991, and issued its Order on Reconsideration on August 21, 1991. The time from the mailing of the Determination Order to the date the Department received claimant's request for reconsideration is 174 days. This figure was arrived at by excluding the date of the Determination Order and the date the request for reconsideration was

received, in accordance with the last sentence of ORS 656.268(5). See Steven E. Edgerly, supra, Robert E. Payne Sr., supra. Thus, claimant had six more days after the August 21, 1991 Order on Reconsideration, (i.e., no later than August 27, 1991), to file a request for hearing.

Claimant's hearing request was filed on August 29, 1991, the date it was received by the Board. OAR 438-05-046(1). Therefore, the request was untimely.

Claimant argues that his request for hearing was timely. Relying on David J. Deering, 43 Van Natta 2346 (1991), claimant argues that: (1) the mailing date of the request for reconsideration tolls the 180 day period within which he had to request a hearing on the Notice of Closure; and (2) the mailing date of the request for hearing on the Order on Reconsideration is the proper date to consider when determining the date claimant filed his hearing request. Claimant's argument fails on both counts.

First, David J. Deering, supra, is inapposite regarding requests for reconsideration. Deering applies OAR 438-05-046(1), which is a Board rule. That rule does not apply to a request for reconsideration, which is controlled by OAR 436-30-050, a Department rule. In addition, the clear language of OAR 436-30-050(3) states that the 180 day time limit to request reconsideration of a Notice of Closure is tolled upon receipt of the request, not on the mailing of the request.

Second, in regard to claimant's argument that the mailing date of the hearing request should control, Deering is distinguishable on the facts. In Deering, we held that the postmark on the envelope containing the request for hearing rebutted the presumption under OAR 438-05-046(1)(b) that the request had been untimely filed. Here, the file does not contain the envelope in which the request for hearing was mailed. Therefore, the record does not contain evidence to rebut the presumption that the request received by the Board after the filing deadline was untimely.

Claimant also asserts that the date on the hearing request establishes the mailing date. The hearing request is dated August 28, 1991. Thus, even if the request was mailed on this date, it would still be untimely since the filing deadline was August 27, 1991. Furthermore, the Court of Appeals has held that there is no presumption that a document is mailed on the date it is dated or on the date it is written. Madewell v. Salvation Army, 49 Or App 713, 716 (1980).

Accordingly, we agree with the Referee that claimant's hearing request is untimely.

ORDER

The Referee's order dated March 31, 1992 is affirmed.

In the Matter of the Compensation of
BREN R. ATHENS, Claimant
WCB Case Nos. 91-15262, 91-06460, 91-11449, 91-13080 & 91-15754
ORDER ON REVIEW
Patrick K. Mackin, Claimant Attorney
Terrall & Associates, Defense Attorneys
Roberts, et al., Defense Attorneys
Michael Whitty (Saif), Defense Attorney
Cooney, et al., Defense Attorneys
Hallock & Bennett, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of that portion of Referee Bethlahmy's order that found it responsible for claimant's left and right carpal tunnel syndrome. Claimant cross-requests review of that portion of the order that declined to award a penalty or attorney fee for an allegedly unreasonable denial against SAIF or, alternatively, Kemper. On review, the issues are responsibility and penalties and attorney fees. We reverse.

FINDINGS OF FACT

Claimant worked for Laidlaw Transit as a school bus driver from August 1985 through March 1986. From November 1, 1988 through February 3, 1989, claimant worked as a cashier at a 7-Eleven.

In October 1989, an Opinion and Order issued finding Laidlaw Transit responsible for a left carpal tunnel syndrome and Kemper, on behalf of 7-Eleven, responsible for a right carpal tunnel syndrome. (Ex. 23). The Board affirmed the order in March 1991. (Ex. 32). On August 12, 1991, claimant entered into a Disputed Claim Settlement with Laidlaw with respect to her left carpal tunnel syndrome claim. Laidlaw is not a party to this proceeding.

In April and May, 1989, and a six-week period in September and October 1989, claimant worked for Adia Temporary Services, insured by Cigna.

From May until October 1989, claimant was employed at Barrett Business Services, a temporary agency, working at Nike as a production worker.

From October, 1989, through December 1990, claimant worked for Regency Park Living Center, insured by Liberty Northwest, as a medical aide.

On May 13, 1991, claimant began working as a trainee at Oregon Health Sciences University, insured by SAIF. After working there for eight days, claimant underwent bilateral carpal tunnel release in both hands. Claimant had been planning on having the surgery since November 1988, (tr. 48), but did not schedule the surgery until after the Board affirmed the Referee's order finding her conditions compensable, (*id.* at 53).

SAIF, Kemper, and Liberty Northwest all denied compensability and responsibility for claimant's left and right carpal tunnel syndrome. Cigna de facto denied the claim.

Claimant was examined by Drs. Phipps, Radecki and Nolan.

CONCLUSIONS OF LAW AND OPINION

Responsibility

We first note that the Referee dismissed claimant's requests for hearing from Cigna and Barrett Business Services' denials on the basis that claimant did not timely file her claim against either carrier. Those dismissals are not contested on review. Therefore, we do not consider any claims against Cigna or Barrett Business Services and focus on whether responsibility shifts to the remaining carriers, Liberty Northwest or SAIF.

The Referee concluded that SAIF was responsible for claimant's left and right carpal tunnel syndrome, finding that claimant proved that her work at OHSU was the major contributing cause of a worsening of the condition. SAIF challenges that conclusion, asserting that claimant neither proved that her condition worsened due to her employment at OHSU nor that any worsening was due, in major part, to her work at OHSU.

Claimant has an accepted right carpal tunnel syndrome with Kemper and an accepted left carpal tunnel syndrome with Laidlaw Transit. Therefore, responsibility for each condition presumptively remains with the respective carrier unless claimant sustained a "new compensable injury" involving the same condition while a subsequent carrier was on the risk. See ORS 656.308(1). Specifically, because the disputed conditions are occupational diseases, there must be proof that subsequent work activities with another carrier were the major contributing cause of a pathological worsening of the right and left carpal tunnel syndrome in order for responsibility to shift. See Donald C. Moon, 43 Van Natta 2595 (1991).

The record contains four opinions regarding this issue. Dr. Brett, neurological surgeon, claimant's treating physician, reported that there were "no other new injuries with her original injury as a school bus driver being her major contributing factor and then her subsequent employment with Hall Laboratories and Sutherland Corporation, as well as her present work at Oregon Health Sciences University, resulting in further nerve entrapment and leading to her need for surgery." (Ex. 40-2). Dr. Brett later reported that claimant's "continued occupation in her employment for Hall Laboratories as well as for Oregon Health Sciences University did independently contribute to her pathologic worsening resulting in symptomatic worsening and leading to the eventual need for bilateral carpal tunnel release." (Ex. 67).

Dr. Phipps, neurologist, conducted an independent medical evaluation. He found that:

"the activities [claimant] is [sic] exposed to throughout life all contribute. * * * It would appear that her subsequent employment from the time that she became symptomatic has not been the major contributing factor in developing the problem nor has it materially worsened the underlying condition. Basically, she was felt by Dr. Brett to require surgical intervention in late 1988 and that was still his feeling in April of 1991 [when] she was seen again. Certainly, her activities in the intervening time were a contributing cause for her ongoing symptoms but they do not appear to be the major contributing cause." (Ex. 45-4).

Dr. Radecki, electrodiagnostic medicine specialist, also conducted an independent medical evaluation. He concluded that the "employment at OHSU did not contribute to the pathological worsening of [claimant's] underlying condition because of the brevity of her work there and the fact she had no change in symptoms. There is no objective evidence that she worsened during that period." (Ex. 66-2). Instead, Dr. Radecki found that "the primary contributing cause of her carpal tunnel syndrome was her familial tendency to develop carpal tunnel syndrome with her mother having it and her half-sister. * * * I believe it was very likely that it was inevitable that [claimant] would eventually develop carpal tunnel syndrome and the type of work she was doing was not significant in its contribution." (Id. at 3).

Finally, Dr. Nolan, hand surgeon, conducted an independent medical evaluation. He concluded that "it is certainly difficult for me to understand how her brief work exposure in a 7-Eleven store could be considered a major contributing cause [of] right carpal tunnel condition" and that it was more reasonable to conclude "that any of the later (after February 1989) work exposures could have contributed more to the exacerbation of her symptoms and the subsequent need for treatment." (Ex. 68-2).

We conclude that the medical evidence in no way indicates that claimant's work activities at Liberty Northwest's insured, Regency Park Living Center, were the major contributing cause of a worsening of her left and right carpal tunnel syndrome. Furthermore, we find that there is insufficient proof that claimant's work activities at SAIF's insured, OHSU, were the major contributing cause of a worsening of her condition. Drs. Phipps and Nolan opined that claimant's subsequent work activities were a factor in contributing to her condition, but not the major contributing cause. Dr. Radecki attributed any worsening to a familial disposition rather than work.

Finally, Dr. Brett reported that claimant's work activities at OHSU independently contributed to

a pathological worsening. However, we find that his opinion does not indicate that such work activities were the major contributing cause. Although reporting that the work activities at OHSU were a cause, there is no indication as to the extent of that contribution. Furthermore, Dr. Brett includes claimant's work at Hall Laboratories as also contributing to a worsening, thus indicating that work at OHSU was not the major factor.

Therefore, finding a failure of proof that claimant's work activities at SAIF's insured and Liberty Northwest's insured were the major contributing cause of a pathological worsening of claimant's condition, we conclude that responsibility does not shift to those carriers. Consequently, responsibility for claimant's right carpal tunnel syndrome rests with Kemper.

Claimant entered into a disputed claim settlement with Laidlaw Transit concerning her left carpal tunnel syndrome. Therefore, having found that responsibility for this condition does not shift, claimant is not entitled to further compensation with regard to her claim for left carpal tunnel syndrome. See Jack Spinks, 43 Van Natta 1351 (1991), aff'd mem Spinks v. Mosley and Sons et al, 112 Or App 661 (1992) (finding that claimant was not entitled to further compensation against the responsible carrier since he had settled his claim with that carrier by entering into a Disputed Claim Settlement).

Penalties and Attorney Fees

The Referee declined to award penalties and attorney fees against any carrier on the basis that its denials were unreasonable, as claimant asserted. On review, claimant contends that, if we also find that SAIF is responsible, she is entitled to penalties and attorney fees. Alternatively, claimant asserts that Kemper's denial was unreasonable.

Having concluded that responsibility did not shift to SAIF, there are no "amounts then due" against SAIF, thus precluding a penalty. See ORS 656.262(10). Furthermore, we agree with the Referee that SAIF and Kemper had legitimate doubts concerning their liability. Parenthetically, we note that, if we had concluded that claimant was entitled to a penalty under ORS 656.262(10), claimant would not be entitled to the assessment of an attorney fee under ORS 656.382(1), inasmuch as the factual bases asserted by claimant in support of a penalty and attorney fee are the same. See Nicolasa Martinez, 43 Van Natta 1638, 1640 (1991), aff'd Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

In setting aside SAIF's denials for claimant's right and left carpal tunnel syndrome claims, the Referee awarded a \$2,000 carrier-paid attorney fee to be paid by SAIF. Inasmuch as we have found Kemper responsible for the right carpal tunnel syndrome claim, it follows that Kemper is responsible for that portion of the Referee's attorney fee award which pertained to that claim as well as an attorney fee award for services on review concerning that claim.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we award claimant's attorney a reasonable fee of \$2,000 for services at hearing and on review concerning the right carpal tunnel syndrome claim, to be paid by Kemper. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's respondent's brief and affidavit in support of attorney fees at Board review), the complexity of the issue, and the value to claimant of the interest involved.

Since we have found that claimant is not entitled to further compensation regarding her left carpal tunnel syndrome claim, it follows that claimant is not entitled to an attorney fee at hearing or on review concerning that issue.

ORDER

The Referee's order dated January 17, 1992 is reversed in part and affirmed in part. That portion of the order finding SAIF responsible for claimant's right and left carpal tunnel syndrome is reversed. SAIF's denial is reinstated and upheld. Kemper's denial of claimant's right carpal tunnel syndrome is set aside and the claim is remanded to Kemper for processing according to law. In lieu of the Referee's attorney fee award, claimant's attorney is awarded \$2,000 for services at hearing and on review concerning the right carpal tunnel syndrome claim, to be paid by Kemper. The remainder of the order is affirmed.

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

Claimant requests review of the SAIF Corporation's September 30, 1992, Notice of Closure which closed his claim with an award of temporary disability compensation from February 5, 1992 through September 14, 1992. SAIF declared claimant medically stationary as of September 15, 1992. Claimant contends that he is entitled to additional benefits as he is not medically stationary.

SAIF has submitted a chart note dated September 15, 1992 from Dr. Matteri, treating M.D., which states claimant is medically stationary, that the his claim should be closed, and that no further orthopedic followups were planned. In addition, in a chart note dated October 16, 1992, Dr. Matteri restates that claimant is medically stationary be all criteria. Furthermore, Dr. Matteri, in a letter dated October 20, 1992, states that claimant is not currently attending physical therapy and that his attendance at physical therapy has been "luke warm" at best.

However, claimant contends that even though Dr. Matteri has previously stated that he is medically stationary, Dr. Matteri contradicted that statement in his October 20, 1992 letter when he opined that "therapy and continued vigorous use of his leg will strengthen [claimant's] knee. However, it is entirely probably [sic] that this is going to take place over a prolonged period of time--months to even years."

An injured worker is considered medically stationary when no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). It is claimant's burden to establish that he was not medically stationary when the claim was closed. Berliner v. Weyerhaeuser, 54 Or App 624 (1981).

We find that, even though Dr. Matteri opined that vigorous use of claimant's leg will strengthen claimant's knee, there is no evidence that a material improvement is expected with the passage of time. There are no physical therapy treatments ongoing and no futher ortheopedic followups planned. Under those circumstances, we find that SAIF properly closed the claim.

Accordingly, SAIF's September 30, 1992, Notice of Closure is affirmed in its entirety.

IT IS SO ORDERED.

December 21, 1992

Cite as 44 Van Natta 2472 (1992)

In the Matter of the Compensation of
CHARLENE K. BARNES-PEACOCK, Claimant
WCB Case No. 92-00565
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Schwabe, et al., Defense Attorneys

Reviewed by Board Members Hooton and Kinsley.

Claimant requests review of Referee Myers' order that upheld the insurer's denial of her claim for a low back injury. On review, the issue is compensability.

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

The Referee found that claimant's witness had testified that claimant told her about the injury at 11 a.m. on the date it allegedly occurred. Rather, the record reflects that claimant's witness, Monique Keen, testified that she started her work shift at 11 a.m. on the date of the alleged injury and that

claimant told her about the injury "later on that day shortly after [she] got to work when [they] both had time." (Tr. 7).

Notwithstanding this modification, we agree with the Referee's credibility finding based on the following inconsistencies in the record. Claimant's injury allegedly occurred at 2:15 p.m. on September 14, 1991. (Ex. 1). Claimant testified that she felt "[g]reat" when she began her work shift that morning. (Tr. 14-15). However, Ms. Keen testified that when she began her shift at 11 a.m. claimant appeared to be physically slower and in discomfort. (Tr. 11).

Claimant told the insurer's claims examiner that she had a bruise on her right hip where she struck the cash register stand. (Ex. 4-9). However, she later testified that she had no bruises. (Tr. 17).

Because claimant's alleged injury was unwitnessed, her credibility is a critical element of her claim. Given the aforementioned inconsistencies, as well as those cited by the Referee, we do not find claimant to be credible.

ORDER

The Referee's order dated March 25, 1992 is affirmed.

December 31, 1992

Cite as 44 Van Natta 2473 (1992)

In the Matter of the Compensation of
KAREN S. MCKILLOP, Claimant
WCB Case No. 90-03325
CORRECTED ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Employers Defense Counsel, Defense Attorneys

Reviewed by Board Members Kinsley, Brazeau and Hooton.

The insurer requests review of those portions of Referee Livesley's order that: (1) assessed a penalty and related attorney fee for its failure to pay interim compensation ordered by an earlier referee; (2) assessed a penalty for its failure to pay temporary disability benefits for the period from February 5, 1988 through December 13, 1988; and (3) assessed a penalty for its allegedly unreasonable claims processing, based on its "reclassification" of the claim as nondisabling. On review, the issues are claims processing, penalties and attorney fees. We affirm in part, modify in part, and reverse in part.

FINDINGS OF FACT

In November 1988, claimant filed an occupational disease claim for an upper extremity overuse syndrome. The insurer checked the "disabling" box on claimant's 801 form, but denied the claim, in part, because it was not timely. Claimant requested a hearing, raising the issues of timeliness, compensability and entitlement to interim compensation. A hearing was held before Referee McWilliams, who found the claim was not time-barred under ORS 656.807(1), because claimant first became disabled in February 1988. By Opinion and Order dated January 4, 1990, Referee McWilliams directed the insurer to pay claimant benefits for interim compensation from April 13, 1988, the date it first had knowledge of the claim, through December 13, 1988, the date of its denial. She also found the claim compensable and remanded it to the insurer for further processing. Referee McWilliams' order was affirmed by this Board, Karen S. McKillop, 43 Van Natta 273 (1991), and ultimately by the Court of Appeals. Bohemia Inc. v McKillop, 112 Or App 261 (1992).

In March 1990, the insurer notified claimant that it was "reclassifying" her claim as nondisabling. As a result of that decision, the insurer paid no benefits for temporary disability, including the benefits for interim compensation previously awarded. Claimant then initiated this proceeding, seeking penalties and attorney fees for the insurer's failure to pay compensation due under the prior order and its allegedly unreasonable reclassification and processing of the claim.

On June 14, 1990, Referee McWilliams convened a second hearing, but then recused herself due

to her prior involvement in the case. The hearing continued on November 29, 1990 before Referee Livesley, who advised claimant that initial jurisdiction regarding the proper classification of the claim might lie with the Evaluation Division of the Department of Insurance and Finance. Claimant then contacted the Department the following day and requested a determination as to the disabling nature of her claim. By letter dated January 18, 1991, the Department denied the request, asserting that it lacked jurisdiction to review the classification of a claim more than one year after the date of injury. Referee Livesley admitted a copy of the denial letter into the record and, on April 15, 1991, issued his order that:

(1) required the insurer to once again pay claimant benefits for interim compensation for the period of April 13, 1988 to December 13, 1988 and assessed a penalty and attorney fee on that amount;

(2) found that claimant was entitled to temporary disability benefits from February 5, 1988 to December 13, 1988,¹ and assessed a penalty on that amount for the insurer's unreasonable failure to process the claim; and

(3) reclassified claimant's claim as disabling and assessed a penalty on any compensation due as a result of the reclassification.

CONCLUSIONS OF LAW AND OPINION

The insurer seeks review of Referee Livesley's award of penalties and attorney fees for its allegedly unreasonable resistance to the payment of compensation and improper claims processing. Because claimant requested a hearing in this matter before May 1, 1990, and a hearing was convened before July 1, 1990, this matter is determined pursuant to the law in effect before July 1, 1990. See Or Laws 1990 (Special Session), ch 2, § 54(2); Astoria Plywood Company v. Culp, 115 Or App 737 (1992); Ida M. Walker, 43 Van Natta 1402 (1991). We affirm in part, modify in part and reverse in part.

Penalty--Failure to Pay Interim Compensation

Referee Livesley first concluded that the insurer acted unreasonably when it refused to pay benefits due under the first order, because Referee McWilliams' finding of disability precluded it from refusing to pay the interim compensation on the basis that claimant's condition was nondisabling. The insurer argues that issue preclusion does not apply, because the purpose of Referee McWilliams' finding of disability was simply to support the determination that the claim was filed timely.

We agree that a threshold issue raised before Referee McWilliams was whether claimant's occupational disease claim was time-barred under ORS 656.807. We also acknowledge that, in order to make that determination, Referee McWilliams needed to determine when and if claimant became disabled. Thus, had that been the sole issue raised at the first hearing, we might agree that issue preclusion would not apply, because the insurer would not have had the opportunity to assert whether the claim, if filed timely and compensable, was disabling. See Hanes v. Washington County Community Action, 107 Or App 304 (1991). cf. Drews V. EBI Companies, 310 Or 134, 139, (1990).

However, Referee McWilliams also was presented with and did, in fact, decide the additional issue of claimant's entitlement to interim compensation. Specifically, Referee McWilliams ordered the insurer to pay claimant interim compensation for the period from April 13, 1988, the date it first had knowledge of the claim, through December 13, 1988, the date of its denial. Thus, in subsequently ordering payment of those benefits, Referee Livesley did not decide the issue on the basis of claimant's disability, but rather held only that the insurer was required to comply with Referee McWilliams' valid and enforceable order. See Glen D. Roles, 43 Van Natta 278, recon 43 Van Natta 379, rev'd on other grounds, SAIF v. Roles, 111 Or App 597 (1991). The insurer's apparent belief that the award of interim compensation was made in error may be grounds for an appeal in the first proceeding. It is not, however, a legitimate basis for the failure to comply with the order.

¹ At hearing, the parties agreed that claimant's entitlement to temporary disability benefits after the date of the insurer's denial would be reserved for a later hearing.

Because the insurer has not paid the required interim compensation, and because its filing of a request for review did not stay the payment of that compensation, see former ORS 656.313(1), we agree with the Referee that the insurer unreasonably resisted the payment of compensation. Accordingly, a penalty is assessable under former ORS 656.262(10) equal to 25 percent of interim compensation payable from April 13, 1988 through December 13, 1988. See William Shaw, 43 Van Natta 375 (1991).

Penalty--Claims Processing

Referee Livesley next assessed a penalty for the insurer's failure to commence payment of temporary disability benefits. He reasoned that the insurer had the duty under the first order to determine whether claimant was entitled to benefits for additional periods of temporary disability compensation prior to the time period covered by the award of interim compensation which began April 13, 1988. Because the medical evidence established that claimant was first disabled from her compensable injury on February 5, 1988, the Referee concluded that, in failing to commence payment of any time loss, the insurer had unreasonably resisted the payment of compensation. He, therefore, assessed a penalty under former ORS 656.262(10).

After our review, we agree with Referee Livesley that claimant left work for reasons related to her compensable conditions on February 5, 1988. Consequently, we adopt his conclusion that claimant was entitled to temporary disability benefits beginning February 5, 1988. However, we do not find that the evidence supporting the entitlement to temporary disability benefits from February 5, 1988 through April 12, 1988 is sufficient to remove any legitimate doubt of the insurer's liability for such benefits. Dr. Jewell, the treating physician, reported that, although claimant was off work since February 1988, he never authorized time loss because he considered her disability to be related to multiple factors, including her preexisting mental problems. Moreover, claimant's entitlement to temporary disability benefits for that period had not been previously litigated. Therefore, we conclude that the insurer was not unreasonable in failing to pay temporary disability benefits from February 5, 1988 through April 12, 1988 in response to Referee McWilliams' order. International Paper Co. v. Huntley, 106 Or App 107 (1991); Brown v. Argonaut Ins., 93 Or App 588 (1988).

Penalty--Nondisabling Classification of Claim

Based on his finding that claimant was entitled to benefits for temporary disability, Referee Livesley also concluded that claimant's condition was properly classified as disabling. Accordingly, he assessed a penalty for the insurer's "reclassification" of claimant's claim as nondisabling.

At hearing, the insurer argued that Referee Livesley lacked jurisdiction to address the proper classification of the claim, because claimant failed to exhaust her administrative remedies under former ORS 656.262(6)(b) and former ORS 656.268(8). We have held that a determination by the Department as to the disabling nature of the claim is a condition precedent to a request for a hearing on that issue. See Randy G. Fisher, 42 Van Natta 635 (1990). Given the unusual facts in this case, we are uncertain as to whether that requirement is applicable here. We need not decide that issue, however, because even if claimant was required to present her claim to the Department, she has done so. As noted by Referee Livesley, claimant wrote the Department on November 30, 1990 and requested a determination as to the disabling nature of her claim. Although the Department denied her request on the basis that it lacked jurisdiction,² its decision constitutes an order denying a request for reclassification. See Forelaws on Board v. Energy Facility Siting Council, 303 Or 541 (1987). Because that order was obtained and joined to the present proceeding prior to the closing of the record and without objection by any party, we conclude that Referee Livesley had jurisdiction over this matter. See OAR 438-06-031 (Permitting additional issues to be raised at hearing).

² The Department may have considered claimant's request as one that a nondisabling injury has become disabling and concluded that, because the request was made more than one year after the date of injury, it must be analyzed as a claim for an aggravation pursuant to ORS 656.277(2). However, as the court explained in Davison v. SAIF, 80 Or App 541 (1986) (regarding a similar provision at former ORS 656.262(12)), that provision applies only to a claim that was initially nondisabling and became disabling. It does not apply to a disabling claim that was misclassified as nondisabling, as claimant alleges here.

The Department may also have considered the request under ORS 656.273(4)(b) as a claim that had been in a nondisabling status for one year from the date of injury. However, the status of the claim was not established until acceptance. Therefore, the claim was not in a nondisabling status for one year.

After our review, we agree with Referee Livesley that claimant's condition is disabling and that she is entitled to a penalty for the insurer's "reclassification" of the claim as nondisabling following the first proceeding. When there is a legitimate dispute between parties as to the disabling nature of a compensable claim, the insurer or self-insured employer is entitled to process the claim as nondisabling. In this case, however, any dispute as to the disabling nature of the claim had been resolved in favor of disability. While Referee McWilliams' order did not explicitly require the acceptance of the claim as disabling, it did specifically find that claimant left work because of her compensable condition and was entitled to benefits for interim compensation. Because the finding of disability was necessary for the determination of claimant's entitlement to interim compensation, Bono v. SAIF, 298 Or 405 (1984), the insurer could not have had a legitimate doubt as to the disabling nature of the claim. Consequently, we conclude that the insurer's actions resulted in an unreasonable resistance to the payment of compensation. Former ORS 656.262(10). For its unreasonable classification of the claim as nondisabling, the insurer is assessed an additional amount equal to 25 percent of the temporary disability benefits payable from February 5, 1988 through April 12, 1988.

ORDER

The Referee's order dated April 15, 1991 is affirmed in part, modified in part, and reversed in part. That claim is classified as disabling. In lieu of the Referee's order, the insurer is directed to pay interim compensation from April 13, 1988 through December 13, 1988, as awarded by the earlier Referee. Claimant is awarded an additional amount equal to 25 percent of this compensation as a penalty for the insurer's unreasonable failure to comply with the earlier Referee's order. The insurer is also directed to pay benefits for temporary disability from February 5, 1988 through April 12, 1988. Claimant is also awarded an additional amount equal to 25 percent of this compensation as a penalty for the insurer's unreasonable classification of the claim as nondisabling. Claimant's attorney is awarded 25 percent of the increased compensation created by the award of benefits from February 5, 1988 through April 12, 1988, not to exceed \$1,050. The Referee's attorney fee award for the insurer's unreasonable conduct is affirmed.

December 22, 1992

Cite as 44 Van Natta 2476 (1992)

In the Matter of the Compensation of
BRENDA K. ALLEN, Claimant
 WCB Case No. 91-08314
 ORDER ON RECONSIDERATION
 Galton, et al., Claimant Attorneys
 Stoel, et al., Defense Attorneys

The insurer requests reconsideration of our November 10, 1992 Order on Review that reversed the Referee's order insofar as it upheld the insurer's denial of claimant's mental disorder claim. On December 3, 1992, we abated our order to allow claimant an opportunity to respond. Inasmuch as claimant's response and the insurer's reply have been received, we proceed with our reconsideration.

Noting that claimant experienced work conditions of reasonable disciplinary, corrective or job evaluation actions by her employer, the insurer takes issue with our conclusion that claimant's overtime and out-of-town travel work were the major cause of her mental disorder. Moreover, the insurer observes that our order failed to expressly apply the "clear and convincing standard" as required by ORS 656.802(3)(d).

We found that the employer's disciplinary, corrective or job evaluation actions were reasonable. Yet, the existence of reasonable disciplinary actions does not necessarily equate with a failure to prove an occupational disease claim for a mental disorder. See Katherine F. Taylor, 44 Van Natta 920, 921 (1992). Rather, claimant's burden is to prove by clear and convincing evidence that work-related stressors, not otherwise excluded under ORS 656.802(2), are the major cause of her mental disorder. See Aetna Casualty Co. v. Aschbacher, 107 Or App, rev den 312 Or 150 (1991).

Because we have found that the employer's disciplinary actions were reasonable, those actions are excluded under ORS 656.802(2)(b) and may not be considered in the analysis of the major cause of her psychological disability and need for treatment. See Katherine F. Taylor, supra. Hence, claimant must establish by clear and convincing evidence that her overtime and out-of-town travel work were the major contributing cause of her mental disorder. Relying on the opinion of Dr. Parvaresh, a psychiatrist who conducted an independent medical examination, the insurer asserts that claimant has not met this requisite burden of proof.

After a review of the conflicting medical opinions, we initially found the opinion of Dr. Altfas, claimant's treating psychiatrist, as supported by claimant's treating medical physician, Dr. Clifton, most persuasive. In reaching this conclusion, we relied on the doctors' comparatively long-term involvement with claimant and the logical force behind their conclusions. After further review of the record, and consideration of the parties' arguments on reconsideration, we continue to agree with that determination. However, we offer the following supplementation.

Dr. Altfas had seen claimant numerous times by the time he offered his opinion. Diagnosing "Major Depression, Recurrent, without Psychosis," Dr. Altfas attributed the major cause of these problems to the stress of 12 to 16 hour work days and extensive traveling three to four days out of the week. (Ex. 60-1). Dr. Altfas was aware that claimant's supervisors had taken some disciplinary measures ("Pt ran across memo addressed to her. Pt is being warned re: absences"). (Ex. 48). Nevertheless, the employer's disciplinary actions were not among the factors Dr. Altfas cited as contributing to claimant's depression.

Dr. Clifton, claimant's longtime treating medical doctor, corroborates Dr. Altfas's opinion. It was Dr. Clifton's opinion that most of claimant's problems arose from her work for the employer; specifically, working extensive overtime hours and long hours spent traveling. (Exs. 66, 67). Furthermore, Dr. Clifton was aware that claimant's supervisors had taken some disciplinary measures (claimant said she was "being criticized"). (Ex. 44).

The insurer contends that the opinion of Dr. Altfas is unpersuasive on the basis that he failed to render an opinion discussing the effects of excessive medication on claimant's mental condition. We continue to disagree with that contention.

As noted in our prior order, inasmuch as Dr. Altfas was aware of claimant's overmedication yet continued to conclude that her work conditions were the major cause of her psychological condition, we find no persuasive reason to discount Dr. Altfas's opinion. Further, because Dr. Altfas is the physician who initiated claimant's Pamelor therapy (to allow her to cease her intake of Prozac) and monitored her treatment of a structured withdrawal of over-the-counter medications, we continue to adhere to our prior conclusion. See Exhibits 37-3; 55A-3 & 4; 60. Finally, Dr. Altfas specifically and persuasively distinguished claimant's overmedication usage as the cause of her chronic headaches and her work situation as the major cause of her Major Depression. (Ex. 60).

The insurer accurately notes that our order concluded that Dr. Parvaresh did not review Dr. Altfas's reports. We acknowledge the oversight. As of the date of his initial opinion on June 15, 1991, Dr. Parvaresh had not reviewed Dr. Altfas's reports. (Ex. 50-1). However, as of the September 25, 1991 deposition, Dr. Parvaresh had reviewed Dr. Altfas's reports. (Ex. 68-24).

Noting that Dr. Parvaresh has reviewed claimant's personnel file, the insurer further contends that Dr. Parvaresh has authored the more persuasive opinion. However, because the personnel file has not been entered into evidence, we are unable to gauge the value of such a review. In any event, both Dr. Altfas and Dr. Clifton were aware of claimant's disciplinary problems. Consequently, Dr. Parvaresh's opinion is not superior to that of the treating physicians.

The insurer also argues that claimant suffers from a preexisting psychological condition characterized as "substance abuse superimposed over a dysthymic disorder." Observing that we neglected to discuss whether claimant's work activities were the major contributing cause of a worsening of this preexisting condition, the insurer asserts that our order is deficient.

Although Drs. Altfas, Clifton and Mertens all recognized that claimant was taking an excessive

amount of over-the-counter medications, none of those physicians diagnosed a "substance abuse" disorder. Further, only Dr. Parvaresh diagnosed claimant as having a dysthymic disorder. Inasmuch as we have not relied on his opinion in our determination, we do not find persuasive evidence that claimant has a preexisting psychological condition. In reaching this conclusion, we expressly do not adopt that portion of the Referee's order which found that claimant suffered from a dysthymic disorder.

In conclusion, on reconsideration, we continue to give greater weight to the treating doctors' opinions. Both Drs. Altfas and Clifton had the opportunity to observe claimant over an extended period of time by treating her psychiatric condition and its medical symptoms. Finding no persuasive reason not to rely on their opinions, we continue to defer to their observations and assessments. Thus, we conclude that claimant has sustained her burden of proving by clear and convincing evidence that her work conditions (excluding the employer's reasonable disciplinary actions) were the major contributing cause of her psychological condition. Accordingly, claimant's mental disorder claim is compensable.

Finally, the insurer requests en banc review of our November 10, 1992 order. While the Board may sit en banc in rendering a decision. Chapter 954, Section 3 (Oregon Laws 1991), it may also sit together in panels. Id.

Our November 10, 1992 order was rendered as a panel. The insurer has advanced no persuasive reason as to why this case should have been reviewed en banc. We, therefore, decline to grant the insurer's request.

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for reconsideration. 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 concerning the insurer's motion for reconsideration is \$650, to be paid by the insurer. This fee is in addition to claimant's previous attorney fee award. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's response on reconsideration and her counsel's affidavit), the complexity of the issue and the value of the interest involved.

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

IT IS SO ORDERED.

December 22, 1992

Cite as 44 Van Natta 2478 (1992)

In the Matter of the Compensation of
GREGG M. BAKER, Claimant
WCB Case No. 91-04387
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Hallock & Bennett, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Bethlahmy's order that upheld the insurer's denial of his claim for a back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of the last sentence.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's testimony did not establish that he sustained a compensable injury or disease. We disagree.

Although the Referee found claimant's testimony to be unpersuasive, she did not make a specific finding regarding claimant's credibility. We, therefore, make our own credibility findings based on the substance of the witnesses' testimony and not on demeanor. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

We note that claimant did not file his claim or seek medical treatment until after he was laid off on January 14, 1991. However, we are unable to find, based upon this record, that claimant is not credible. In this regard, the only testimony that potentially contradicts claimant's version of the events is that of Mr. Holmes. Claimant asserts that on January 10, 1991, he left work early, telling Holmes that his back was "killing" him and he thought he had to go to the doctor. Holmes testified that he did not recall claimant leaving work early or saying that his back was hurting. On cross-examination, Holmes stated that it was possible claimant left work early, but he did not remember this occurring. Claimant's testimony is consistent with the histories given to his physicians and we do not consider Holmes' testimony alone to be sufficient evidence upon which to find that claimant is untruthful.

Claimant testified that he initially felt back pain while moving a stack of chairs in November 1990. In December 1990, claimant felt back pain again after lifting heavy boxes. Claimant was also struck by a gate. Finally, claimant again experienced pain while lifting bails of paper bags on January 10, 1991. Claimant stated that he left work early on January 10, 1991 as a result of the back pain.

The Referee analyzed claimant's injury alternatively as an injury and as an occupational disease. Occupational diseases are distinguished from accidental injuries in that the onset of the former is gradual over a long period of time, rather than within a relatively short, discrete period of time. Further, occupational diseases are not unexpected but recognized as an inherent risk of continued exposure to conditions of the particular employment. Valtinson v. SAIF, 56 Or App 184, 187-88 (1982).

Here, Dr. Longland indicates that claimant did not identify any specific incident as causing his back pain and claimant contends that his back pain arose from a series of incidents involving heavy lifting. Further, when he began the job assignment, claimant had not performed heavy labor for a number of years. Thus, we conclude that claimant's back condition was an expected result of heavy lifting at work which claimant was not used to performing. Because claimant's condition gradually resulted from a series of incidents over a period of several months, and was not unexpected, his condition should be analyzed as an occupational disease.

Accordingly, claimant has the burden to prove, by medical evidence supported by objective findings, that his employment conditions were the major contributing cause of his back condition. ORS 656.802(2).

Claimant was seen by Dr. Longland, an osteopathic physician and Dr. Pettigrew, a chiropractor. Dr. Longland opined that claimant had thoracic and lumbar strain secondary to a work-related injury. Dr. Longland noted objective findings of tenderness to palpation in the lumbó-sacral and thoracic spines and the paravertebral musculature. See Georgia Pacific Corp. v. Ferrer, 114 Or App 471 (1992). Dr. Pettigrew also stated that, in all probability, claimant's back condition was due to the work he was performing. The use of "magic words" or statutory language is not required where the record as a whole satisfies claimant's burden of proof. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). Here, since the physicians did not attribute claimant's back condition to other potential causes, we conclude that claimant's work activities were the major contributing cause of his back condition.

Alternatively, based upon the medical evidence summarized above, we find that claimant's back condition is also compensable as an industrial injury. In this regard, the opinions of Drs. Longland and Pettigrew indicate that the work incidents are a material contributing cause of claimant's back condition. See ORS 656.005(7)(a); Mark N. Weidle, 43 Van Natta 855 (1991). Furthermore, as stated above, Dr. Longland's opinion is supported by objective findings. Accordingly, in the alternative, claimant has established a compensable injury.

Claimant argues that the insurer's denial is unreasonable. However, inasmuch as this issue was not raised before the Referee, we decline to address it on Board review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (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 is \$2,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and appellant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated February 7, 1992 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for acceptance and processing according to law. For services at hearing and on review, claimant's attorney is awarded \$2,500, payable by the insurer.

December 22, 1992

Cite as 44 Van Natta 2480 (1992)

In the Matter of the Compensation of
JOSE M. CAMARGO, Claimant
WCB Case No. 91-12967
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Holtan's order that declined to address the issue of entitlement to temporary disability benefits for the period of October 6, 1989 through July 16, 1990. On review, the issue is jurisdiction. We affirm.

FINDINGS OF FACT

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

Claimant's claim was first closed by an August 28, 1990 Notice of Closure. A corrected Notice of Closure issued January 9, 1991, and awarded claimant temporary disability benefits from September 27, 1989 through October 6, 1989. The Notice found that claimant was medically stationary as of July 16, 1990. No permanent disability benefits were awarded.

On February 22, 1991, claimant requested reconsideration of the Notice of Closure. In addition to disagreeing with the impairment findings of his treating physician, claimant also checked boxes indicating that he disagreed with the medically stationary date and temporary disability benefits awarded by the Notice of Closure.

An August 30, 1991 Order on Reconsideration issued which affirmed the Notice of Closure in all respects. No medical arbiter was appointed prior to the Order on Reconsideration.

On September 12, 1991, claimant requested a hearing from the Order on Reconsideration. Claimant's hearing request specified the issues as temporary disability benefits and extent of disability. In a December 9, 1991 letter to the Referee, claimant reiterated that "the issue raised for consideration is claimant's appeal of the Order on Reconsideration dated August 30, 1991 . . . Specifically, claimant has raised issues regarding his entitlement to additional time loss and scheduled permanent partial disability."

CONCLUSIONS OF LAW AND OPINION

Relying on Olga I. Soto, 44 Van Natta 697 (1992), the Referee concluded that the Order on Reconsideration was invalid because the Department failed to appoint a medical arbiter. He therefore found that jurisdiction over the matter remained with the Department.

On review, claimant argues that the Referee should have determined the issue of his entitlement to temporary disability benefits from October 6, 1989, through July 16, 1990, regardless of whether or not the Order on Reconsideration was invalid. We disagree.

Under the circumstances, we conclude that the issue before the Referee involved claimant's substantive right to temporary disability benefits. We disagree with claimant's characterization of the issue as one of "procedural" entitlement to temporary disability, as the claim had been closed in January 1991, and claimant has sought to have the Notice of Closure modified to provide for temporary disability benefits through July 6, 1990, rather than through October 6, 1989, as provided by the Notice of Closure.

Accordingly, because the Hearings Division lacks initial jurisdiction to address a direct challenge to a Notice of Closure regarding a worker's substantive entitlement to temporary disability, see Ralph E. Fritz, 44 Van Natta 1168 (1992), we conclude that the Referee correctly did not address the issue of temporary disability benefits. See also Galvin C. Yoakum, 44 Van Natta 2403 (1992). Claimant must first seek reconsideration of the Notice of Closure by the Department and a valid Order on Reconsideration must issue before the Board and Hearings Division have jurisdiction to consider claimant's request for hearing and review regarding the temporary disability issue. See Robert G. Edwards, 44 Van Natta 2368 (1992) (once Order on Reconsideration invalidated on Soto grounds, Referee lacked jurisdiction to consider premature claim closure issue).

The Referee's order is, therefore, affirmed.

ORDER

The Referee's order dated April 24, 1992 is affirmed.

December 22, 1992

Cite as 44 Van Natta 2481 (1992)

In the Matter of the Compensation of
HAROLD L. DOWNEY, Claimant
WCB Case No. 91-16319
ORDER ON REVIEW (REMANDING)
Burt, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

Claimant requests review of Referee Michael V. Johnson's order which: (1) set aside an Order on Reconsideration on the ground that it was invalidly issued; and (2) found that jurisdiction remained with the Appellate Unit of the Workers' Compensation Division (WCD). Noting that he has waived his request for the appointment of a medical arbiter, claimant seeks remand to the Referee for the convening of a hearing. 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's request for reconsideration evidenced a disagreement with the impairment findings.

CONCLUSIONS OF LAW AND OPINION

The Referee set aside the Order on Reconsideration and found that jurisdiction remained with the WCD Appellate Unit. We find that the Order on Reconsideration is valid for review. We also find that the record is incompletely developed and we remand.

We have previously held that an Order on Reconsideration is invalid, and we therefore lack jurisdiction to consider a request for hearing concerning the Order on Reconsideration, if the basis for objection to the Notice of Closure or Determination Order is disagreement with the impairment findings used in rating the worker's disability, and the Department fails to appoint a medical arbiter and submit

the arbiter's findings for reconsideration. See ORS 656.268(7); Olga I. Soto, 44 Van Natta 697, 700 (1992), recon den 44 Van Natta 1609 (1992). Further, we more recently held in Brenton R. Kusch, 44 Van Natta 2222 (1992), that if a party whom the mandatory provision is intended to protect waives that mandatory procedure, the Order on Reconsideration is valid for review.

Here, claimant requested reconsideration of the Determination Order on the basis that he did not agree with the impairment findings used in that order. The Order on Reconsideration was issued without the appointment of a medical arbiter. Thus, no medical arbiter's findings were submitted to the Department before the Order on Reconsideration was issued as required by ORS 656.268(7). However, claimant has expressly waived the appointment of a medical arbiter and seeks remand for the convening of a hearing regarding the extent of permanent disability issue. Under such circumstances, we find the Order on Reconsideration valid for review. Brenton R. Kusch, *supra*.

Inasmuch as we have found the Order on Reconsideration valid, the issue of extent of permanent disability is properly before us. However, in light of his conclusion that the Order on Reconsideration was invalid and claimant's hearing request should be dismissed, the Referee concluded the hearing without permitting the parties an opportunity to present testimony. Accordingly, we find that the record is incompletely developed. See Charles R. Butler, 44 Van Natta 994 (1992).

We, therefore, find it appropriate to remand this matter to Referee Michael Johnson for further proceedings consistent with this order. ORS 656.295(5). Such 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 March 20, 1992 is vacated. The matter is remanded to Referee Michael V. Johnson for further proceedings consistent with this order.

December 22, 1992

Cite as 44 Van Natta 2482 (1992)

In the Matter of the Compensation of
MICHAEL A. FERDINAND, Claimant
 WCB Case Nos. 91-09632 & 91-17972
 ORDER ON REVIEW
 Schneider & DeNorch, Claimant Attorneys
 Charles Lundeen, Defense Attorney

Reviewed by Board Members Moller and Neidig.

On October 8, 1992, we withdrew our September 15, 1992 Order of Dismissal. We took this action to consider claimant's contention that the parties did not and could not have resolved their dispute in this case pursuant to an approved August 31, 1992 Claim Disposition Agreement (CDA). The insurer's response has been received. In lieu of our dismissal order, we offer the following order.

As noted in our dismissal order, the insurer requested, and claimant cross-requested, review of a Referee's order that: (1) affirmed an Order on Reconsideration which awarded claimant's attorney an out-of-compensation fee equal to 10 percent of the additional compensation granted by the reconsideration order not to exceed \$420; and (2) found that the insurer's claim processing conduct had not been unreasonable.

On review, the insurer asserted that since the "additional" temporary disability granted by the reconsideration order had previously been paid to claimant while processing the claim prior to claim closure, no "additional" compensation had been awarded on which to base an attorney fee. Claimant contended that his attorney fee payable from the "additional" temporary disability granted by the reconsideration order should not be limited to \$420 and that the insurer's failure to pay the attorney fee granted by the reconsideration order was unreasonable.

On August 31, 1992, prior to conducting our review of the Referee's order, we approved a CDA,

in which claimant released his rights to workers' compensation benefits (including temporary disability), except medical services, for his October 1989 compensable injury. The CDA further provided that the insurer "has paid the claimant all benefits due and payable up to the date this agreement was sent to him." (Page 2, Paragraph 13).

We concluded that the CDA had rendered the parties' appeal moot. In reaching our conclusion, we reasoned that the issues on review were contingent on claimant's entitlement to temporary disability, which had been released under the CDA. Consequently, we dismissed the requests for Board review.

In seeking reconsideration, claimant contends that "the CDA could [not] possibly have disposed of all (or any of the) issues before the Board in this case." We agree that the CDA does not expressly refer to the parties' pending dispute. Furthermore, the parties' current responses do not support a conclusion that there was an express intention to resolve their appeals pursuant to the CDA.

Nevertheless, the CDA expressly provides that claimant has released his rights to temporary disability benefits. Moreover, the parties agreed in the CDA that, at the time the CDA was submitted to claimant, the insurer had paid claimant all currently due benefits. Finally, it is well-settled that attorney fees which are payable out of claimant's compensation retain their identity as compensation. Steiner v. E. J. Bartells Co., 114 Or App 22 (1992); SAIF v. Gatti, 72 Or App 106 (1985); Candy J. Hess, 37 Van Natta 12 (1985).

Under such circumstances, we conclude that the CDA effectively resolved this dispute. See Krieger v. Future Logging, 116 Or App 537 (1992) (procedural mechanism of CDA available for settlement of aggravation claim, regardless of fact that aggravation claim was in litigation). As a result of the CDA, claimant not only released her rights to temporary disability benefits, but agreed that she had received all currently due benefits. Inasmuch as out-of-compensation attorney fees are considered compensation, claimant also relinquished her rights to the attorney fee granted by the reconsideration order and Referee's order. Furthermore, since the basis for any penalty assessment was the insurer's failure to pay the out-of-compensation attorney fee and since claimant has released her rights to such benefits, there has been no unreasonable resistance to the payment of compensation. Consequently, neither penalties nor attorney fees would be warranted.

Accordingly, the Referee's order dated March 6, 1992, as amended March 31, 1992, is reversed in part and affirmed in part. That portion which directed the insurer to pay claimant's attorney an out-of-compensation fee is reversed. The remainder of the Referee's order is affirmed.

IT IS SO ORDERED.

December 22, 1992

Cite as 44 Van Natta 2483 (1992)

In the Matter of the Compensation of
RENE G. GONZALEZ, Claimant
WCB Case No. 91-15032
ORDER ON REVIEW

James L. Edmunson, Claimant Attorney
Kevin L. Mannix, PC, Defense Attorneys

Reviewed by Board Members Westerland and Gunn.

Liberty Northwest Insurance Corporation requests review of Referee Thye's order that set aside its denial of claimant's occupational disease claim for a right shoulder condition. On review, the issue is compensability.

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

The Referee concluded that claimant proved that his shoulder impingement syndrome was compensable as an occupational disease by proving that his work as a meat cutter for 35 years with

various employers was the major contributing cause of his condition. Liberty contends that the Referee erred in this regard. Relying on Garcia v. Boise Cascade Corporation, 103 Or App 508 (1990), Liberty argues that because it rescinded its responsibility denial at hearing so as to deny compensability only, claimant had to prove that his employment conditions at Liberty's insured were the major contributing cause of his condition. We disagree. We conclude, as did the Referee, that although other potentially responsible insurers or employers were not joined as parties, Liberty could be held responsible for the condition if the considerations that are relevant to the determination of responsibility as between Liberty and the absent employers support the conclusion. Here, those considerations clearly support that conclusion.

In its November 14, 1991 notice of denial, Liberty conceded compensability of the condition and denied responsibility only. Liberty's denial was consistent with the evidence, which established that claimant's 35 years of employment as a meat cutter, the last such employer being Liberty's insured, was the major contributing cause of claimant's impingement syndrome. Thus, by the undisputed evidence, claimant established compensability of the claim as to some employer. Therefore, the only possible issue was responsibility.

The problem, however, was that despite asserting responsibility as its defense, Liberty's denial did not meet the requirements of ORS 656.308(2) in that it failed to specify what, if any, employment prior to claimant's last relevant employment with Liberty's insured was responsible for claimant's condition. See OAR 438-05-053. As a consequence, claimant had no obligation to join any prior employers or insurers, because Liberty waived any argument that responsibility should be assigned to some previous employer or insurer. Byron E. Bayer, 44 Van Natta 1686 (1992).

Evidently recognizing this problem, Liberty amended its denial at hearing so as to deny compensability only. Liberty argues now, as it did at hearing, that having rescinded its responsibility denial, it can be held responsible for claimant's condition only if claimant establishes that his work with Liberty's insured was the major contributing cause of the condition. The Referee rejected this argument, observing that:

"The posture of this case is confusing. Despite a statement in the November 14, 1991 denial that claimant's condition is compensable and that only responsibility was being denied (see exhibit 24D-2), the parties agreed at hearing that the issue is compensability, not responsibility. Thus, only compensability will be addressed, and if found compensable, employer will be deemed responsible." (O & O, p. 3).

In other words, the Referee understood the parties to have agreed that if claimant's condition was proven to be related to his employment over the years, Liberty was precluded from claiming that some other employer was responsible, and to that extent, responsibility was not the issue. On the other hand, the Referee concluded that the law of responsibility would continue to be relevant as it pertains to the question of Liberty's liability for claimant's condition. We agree.

The unusual posture of this case is similar to the situation the court faced in Medford Corporation v. Smith, 110 Or App 486 (1992), on remand Donald H. Smith, 44 Van Natta 737 (1992). There, the employer became self-insured after being insured by SAIF for a period of time. The claimant developed right carpal tunnel syndrome because of his work for the employer which involved repetitive hand movements. SAIF accepted a claim for right carpal tunnel syndrome. While SAIF was still on the risk, the claimant developed some left hand symptoms. About ten months after the employer became self-insured, the claimant first sought treatment for left carpal tunnel syndrome. SAIF denied responsibility, and the claimant did not request a hearing on that denial. Ultimately, the claimant filed a claim for the left hand condition against the employer in its self-insured capacity.

Because the claimant did not request a hearing on SAIF's denial, the court held that as a matter of law, SAIF could not be held responsible for the claim and was out of the case. Nonetheless, as to the self-insured employer's liability, the court rejected the employer's argument that the claimant's work exposure before the employer became self-insured could not be considered. The court reasoned that the self-insured employer could be held responsible for the entire condition, "if the considerations that are relevant to the determination of responsibility as between SAIF and the employer while self-insured support that conclusion." Medford Corporation v. Smith, supra at 488-489. The court specifically found

that under responsibility law, those considerations included the claimant's work exposure both before and after the employer became self-insured. *Id.* at 489. Consistent with its decision in *Aetna Casualty Co. v. Aschbacher*, 107 Or App 494, *rev den* 312 Or 150 (1991), the court remanded the case to the Board for a determination of whether the claimant's work exposure as a machinist before and after the employer became self-insured was the major contributing cause of the claimant's left hand condition. On remand, we examined the evidence as to the claimant's work both before and after the change of carriers and found the claim compensable on that basis. *Donald H. Smith, supra.*

We reach that same conclusion here, for the same reasons. Specifically, although responsibility is not at issue in the sense that no other employer/insurer could be assigned responsibility, under the law of responsibility which nonetheless applies, all prior work exposures must be considered for the purpose of deciding the compensability issue presented. The Referee concluded, and we agree, that claimant's employment both before and after Liberty came on the risk was the major contributing cause of claimant's condition. Furthermore, Liberty's insured was both the last employer whose exposure did or could have caused the disease, and who was on the risk at the time claimant's symptoms arose and for which medical treatment was sought. Thus, we agree with the Referee that Liberty is liable for claimant's impingement syndrome condition.

The decision in *Garcia v. Boise Cascade Corp.*, *supra*, upon which Liberty places principal reliance, is inapposite. At the time relevant to that decision, a claimant had the duty to join all potentially responsible employers, or face the prospect of having to establish compensability of the claim without reference to rules governing the assignment of responsibility as between employers for a work-related condition. Subsequent to the *Garcia* decision, the legislature enacted ORS 656.308(2) as part of the 1990 amendments to the Workers' Compensation Law. That statute provides that any insurer which intends to disclaim responsibility on the basis of an exposure with another insurer must specify in its disclaimer, which insurer is allegedly responsible; and only then must the claimant file a claim with such other insurer. Here, Liberty not only failed to comply with this statutory requirement, at hearing, it expressly waived the defense of responsibility. Consequently, Liberty cannot now argue that previous employers are responsible for the claim or deprive claimant of the benefits of the rules which would apply had Liberty complied with ORS 656.308.

Claimant is entitled to an assessed attorney fee for prevailing over Liberty's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the compensability issue is \$200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 17, 1992 is affirmed. For services on Board review concerning the compensability issue, claimant's counsel is awarded \$200, to paid by the insurer.

December 22, 1992

Cite as 44 Van Natta 2485 (1992)

In the Matter of the Compensation of
DARYL S. PUTNAM, Claimant
WCB Case No. 91-04312
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Julene Quinn (Saif), Defense Attorney

Reviewed by Board Members Moller and Brazeau.

The SAIF Corporation requests review of Referee Barber's order that set aside its denial of claimant's aggravation claim for his current right shoulder and neck condition. In its brief, SAIF contends it was an abuse of discretion for the Referee and a prior referee to grant claimant's requests for postponement. On review, the issues are postponement and aggravation. We affirm.

FINDINGS OF FACT

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

Claimant requested a hearing which was set for July 8, 1991. Claimant's counsel appeared, but claimant was not present. The referee issued an Interim Order allowing claimant 30 days to show cause for his failure to appear. Following receipt of claimant's affidavit, the referee granted claimant's motion to postpone and the hearing was reset.

On February 3, 1992, the second date set for claimant's hearing, claimant's counsel appeared but claimant did not. Claimant's counsel moved for a second postponement based upon the Hearing Division's failure to send the second notice of hearing to claimant's new address. The Referee granted claimant's motion for postponement and reset the hearing.

On March 26, 1992, a hearing was convened with all parties, including claimant, present at the hearing.

CONCLUSIONS OF LAW AND OPINION

Postponement

On review, SAIF argues that the Referee and a prior referee should not have granted claimant two postponements. SAIF contends that it was an abuse of discretion for the referees to allow postponements based upon claimant's contention that he did not receive the notices of hearing. We disagree.

Here, claimant did not appear at the first hearing because he had not received notice of the hearing. Claimant's affidavit establishes that, although he moved after requesting a hearing, he believed that his mail would be forwarded to him. Claimant, therefore, failed to appear because he was unaware that a hearing had been set.

With regard to the second hearing, claimant failed to appear for the same reason. The Referee noted, however, that the prior referee's order had been sent to claimant's new address, but the Hearing Division had sent the second notice of hearing to the old address. Claimant's attorney also had continued to send correspondence to claimant's old address and the mail had, again, not been forwarded to claimant.

Under the circumstances, we do not find that claimant abandoned his request for hearing. Moreover, we do not agree with SAIF that either postponement constituted an abuse of discretion. Accordingly, SAIF's motion to remand this matter is denied.

Aggravation

The Referee concluded that claimant established a compensable aggravation of his right shoulder and neck condition. We affirm.

At the outset, SAIF disagrees with the Referee's conclusion that the cervical disc bulges and herniation at C5-6 were part of claimant's compensable claim. We agree with the Referee and add the following supplementation.

Claimant's right shoulder and neck injury occurred on June 4, 1988. The Form 801 provided that claimant had sustained a right shoulder strain. A Form 827 provided that claimant's diagnosis was a cervical strain with "neurospinal compression syndrome."

On July 6, 1988, claimant was diagnosed with a herniated disc at C5-6. On July 11, 1988, claimant's treating doctor, Dr. Hill, requested authorization to perform cervical disc surgery. Dr. Hill also authorized temporary disability benefits.

SAIF denied claimant's claim through an August 12, 1988 Notice of Denial and claimant requested a hearing. On February 9, 1989, the parties entered into a stipulation which stated that

claimant "filed a claim for an alleged injury to the right shoulder and neck." The stipulation set aside SAIF's denial and provided that "the claimant's claim heretofore filed is accepted."

We conclude that the stipulation which accepted claimant's "claim" for his right shoulder and neck "injury" necessarily accepted the herniated disc at C5-6. The disc had been diagnosed prior to the time of the stipulation and claimant's doctor had requested authorization for surgery and had authorized benefits based upon the C5-6 diagnosis. Under the circumstances, we agree with the Referee that the facts of this case establish that SAIF's acceptance of claimant's claim included acceptance of the herniated disc at C5-6. We, therefore, address the merits of claimant's aggravation claim for a worsened C5-6 disc condition.

In order to establish a compensable aggravation, claimant must show a worsened condition resulting from the original injury since the last arrangement of compensation. ORS 656.273(1). To prove a compensable worsening of his unscheduled cervical condition, claimant must show that increased symptoms or a worsened underlying condition resulted in diminished earning capacity. Smith v. SAIF, 302 Or 396 (1986); Edward D. Lucas, 41 Van Natta 2272 (1989), rev'd on other grounds Lucas v. Clark, 106 Or App 687 (1991). Further, the worsening must be established by medical evidence supported by objective findings. ORS 656.273(1) and (3).

We agree with the Referee that the opinion of Dr. Hill, claimant's treating physician, in addition to Exhibit 22, 36A, and claimant's testimony, (Tr. 30), establish that claimant has a worsened condition supported by objective findings. We adopt the Referee's "Conclusions and Opinion" on that issue.

We further find that the worsening has resulted in a loss of earning capacity. By the time of the last arrangement of compensation, claimant was free of pain and had returned to regular work without restrictions. (Ex. 10). Following his aggravation, claimant was unable to operate his own landscaping business on more than a part-time basis, due to pain.

Finally, because claimant has previously received an award of compensation for his cervical condition, he 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).

Here, surgery had originally been requested for claimant, but was never performed. Dr. Langston reported that it was up to claimant and his doctor to determine whether to proceed with surgery or to treat the condition conservatively.

The May 15, 1990 stipulation increased claimant's unscheduled permanent disability award to 21 percent. Prior to the stipulation, claimant's doctor had reported that he was not expected to need further treatment. Claimant was free of pain with no restrictions in the cervical area, and he had returned to regular work. (Ex. 10).

Following his aggravation, claimant had a positive neck compression test, weakness of the biceps, reflex changes and decreased sensation. Dr. Hill, claimant's treating physician, reported that claimant would require surgery for his cervical condition. (Ex. 36-A). The Orthopaedic Consultants opined that the surgery request was not unreasonable. (Ex. 32-5).

We conclude that the record establishes that claimant's worsening is more than a waxing and waning of symptoms contemplated by the May 15, 1990 stipulation. Accordingly, we agree with the Referee that claimant has proven a compensable aggravation. We, therefore, affirm the Referee's order.

Claimant is entitled to an assessed attorney fee for successfully defending against SAIF's request for review on the issue of aggravation. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed fee for claimant's counsel's services on Board review is \$900, to be paid by SAIF. In reaching this conclusion, we have particularly considered the complexity of the issues, the time devoted to the case (as represented by claimant's respondent's brief and statement of services) and the value of the interest involved. In arriving at an attorney fee, we decline claimant's suggestion that the fee be increased because claimant was required to respond to SAIF's argument regarding the scope of acceptance. We disagree with claimant's contention that the aforementioned issue was a frivolous one.

ORDER

The Referee's order dated April 27, 1992 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of \$900, to be paid by the SAIF Corporation.

December 22, 1992

Cite as 44 Van Natta 2488 (1992)

In the Matter of the Compensation of
DAVID G. ROBERTS, Claimant
WCB Case No. 92-01422
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Hooton and Brazeau.

Claimant requests review of that portion of Referee Nichols' order that upheld the SAIF Corporation's denial of his claim for a right wrist 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

The Referee analyzed claimant's right wrist claim as one for an occupational disease. Finding insufficient evidence to prove that claimant's work activities were the major contributing cause of his condition, the Referee concluded that the occupational disease claim is not compensable. On review, claimant argues that his claim should be analyzed as an injury, rather than an occupational disease. We disagree.

Occupational diseases are distinguished from accidental injuries in two respects: (1) unlike injuries, diseases are not unexpected, because they are recognized as an inherent hazard of continued exposure to work conditions; and (2) diseases are gradual rather than sudden in onset. James v. SAIF, 290 Or 343 (1980); Valtinson v. SAIF, 56 Or App 184 (1982); O'Neal v. Sisters of Providence, 22 Or App 9 (1975).

Claimant is employed as a mechanic for recreational vehicles and is required to use a variety of hand tools. His duties include installation of trailer hitches, which requires the use of an electric drill for mounting hitches on vehicles. Claimant testified that his right wrist symptoms began in late August 1991 following an incident in which his drill bit got "caught" during drilling and "snapped" the wrist. (Tr. 8-9). He testified that the pain subsided for a few days and then worsened while he continued to work. (Tr. 9). He sought treatment on September 10, 1991. (Ex. 3).

Claimant's testimony is not supported by the record. The documentary evidence does not relate the onset of claimant's condition to any particular work incident or event. When claimant first sought treatment on September 10, 1991, he reported: "RT wrist pain[.] No known injury." (Ex. 3). Claimant also reported: "Lots of stress on wrist but no specific trauma." (Id.) Additionally, Dr. Harp wrote on the 827 form in the box marked "WORKER'S STATEMENT OF CAUSE AND NATURE OF INJURY OR EXPOSURE": "Repetitive use RT wrist." (Ex. 2).

Because the aforementioned documents were prepared closer in time to the onset of claimant's condition, we conclude that the documents are more reliable than claimant's testimony at hearing. They specifically negate the occurrence of specific trauma and, instead, indicate that claimant's condition gradually developed as the result of repetitive work activities. We find, therefore, that claimant's condition arose gradually. We also find that the condition was not an unexpected result of the inherent hazard of claimant's work activities, which require repetitive use of the hands and wrists. Accordingly, we agree with the Referee's analysis of the claim as an occupational disease. See id.

On the merits, we disagree with the Referee's conclusion that the claim is not compensable. Given the repetitive nature of claimant's work activities, we analyze his occupational disease claim under ORS 656.802(1)(c): "Any series of traumatic events or occurrences which requires medical services or results in physical disability or death." Claimant must prove that work activities were the major contributing cause of the right wrist condition. See ORS 656.802(2). "Major contributing cause" means an activity or exposure or combination of activities or exposures which contributes more to causation than all other causative agents combined. See McGarrah v. SAIF, 296 Or 145, 166 (1983); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983); David K. Boyer, 43 Van Natta 561 (1991), aff'd mem Boyer v. Multnomah County School District No. 1, 111 Or App 666 (1992). Furthermore, existence of the condition must be established by medical evidence supported by objective findings. Id.

The only medical opinion concerning causation is submitted by Dr. Thayer, an orthopedist who examined claimant in January 1992. In his January 15, 1992 chart note, Thayer noted decreased grip strength, pain and swelling in the wrist. (Ex. 5). He diagnosed dorsal capsular syndrome and wrote: "From the description of [claimant's] job and his symptomatology, it would appear logical to me that this is a compensable injury." (Id.)

The Referee was not persuaded by Thayer's uncontroverted opinion, reasoning that it was unclear whether or not Thayer applied the "major contributing cause" standard for occupational diseases. As the Referee noted, however, "magic words" are not essential for claimant to sustain his burden of proof. See McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986).

Thayer's opinion indicates that he believed claimant's right wrist condition to be work related. Inasmuch as Thayer did not discuss any other potential cause for the condition, we further find that his opinion supports a finding that it is more likely than not that work activities were the major, if not the sole, contributing cause of the condition. Furthermore, claimant's testimony establishes that his condition arose and worsened during work activities which required extensive repetitive use of the hands and wrists, and that off-work activities were not nearly so extensive or repetitive. (Tr. 9-17).

Based on this record, we conclude that claimant has sustained his burden of proving that work activities were the major contributing cause of his right wrist condition and the resulting need for treatment. We also conclude that Thayer's chart note establishes the condition with medical evidence supported by objective findings.

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the compensability issue is \$2,500, to be paid by SAIF. 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 April 14, 1992 is reversed in part and affirmed in part. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. The remainder of the order is affirmed. Claimant's attorney is awarded \$2,500 for services at hearing and on Board review, to be paid by SAIF.

In the Matter of the Compensation of
MYRON R. SHAFFER, Claimant
WCB Case Nos. 91-15856 & 91-08527
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys
Julie K. Bolt (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

The SAIF Corporation requests review of Referee Davis' order that: (1) set aside its "back-up" denial of claimant's right knee injury claim; (2) set aside its disclaimer of responsibility for that claim; and (3) upheld Argonaut Insurance Company's (Argonaut) denial of compensability and responsibility for the same claim. In its brief, Argonaut argues that it is materially prejudiced by claimant's filing of an injury claim against it nine years after the 1982 injury. On review, the issues are whether SAIF's "back-up" denial is prohibited and, if not, timeliness and compensability of the claim against Argonaut. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

SAIF denied responsibility for claimant's claim for right knee post-traumatic arthritis 3 1/2 years after accepting that claim. The denial was based on the fact that SAIF did not provide coverage on the date of claimant's injury. (Ex. 62). In addition, SAIF issued a "Disclaimer of Responsibility," stating that Argonaut, not SAIF, provided coverage on the date of injury and that SAIF had not requested appointment of a paying agent. (Ex. 66).

The Referee decided that SAIF's denial was an impermissible "back-up" denial under ORS 656.262(6). In reaching this conclusion, the Referee first noted that the statute specifically limits the time within which an insurer may deny that "the paying agent" is responsible for the claim. Second, in the absence of an express statutory exception and finding no legislative intent concerning denials based on lack of coverage, the Referee concluded that the legislature did not intend to exclude denials based on lack of coverage from the two-year time limitation. Third, finding no public policy supporting such an exception, the Referee concluded that the amended statute limits "back-up" denials, including those based on lack of coverage, to those which issue within two years of claim acceptance. Although we agree that SAIF's denial is prohibited, we reach this result based on the following reasoning.

ORS 656.262(6) provides, in relevant part:

"[I]f the insurer or self-insured employer accepts a claim in good faith but later obtains evidence that the claim is not compensable or evidence that the paying agent is not responsible for the claim, the insurer or self-insured employer, at any time up to two years from the date of claim acceptance, may revoke the claim acceptance and issue a formal notice of claim denial."

By its terms, the statute applies to denials based on "evidence that the claim is not compensable or evidence that the paying agent is not responsible for the claim." Here, SAIF's denial is based on lack of coverage, rather than on evidence that the claim is not compensable or that the paying agent is not "responsible" under responsibility law. In addition, although SAIF separately disclaimed "responsibility," its disclaimer is actually based on lack of coverage.

Before the 1990 amendments to ORS 656.262, a clear distinction was drawn by the courts between "back-up" denials based on "lack of coverage" and "back-up" denials of compensability or responsibility. The latter were prohibited or severely restricted by the rule of Bauman v. SAIF, 295 Or 788 (1983). The former were not, as the court explained in Oak Crest Care Center v. Bond, 101 Or App 15, 19 (1990):

****Bauman protects a claimant from vacillation on issues of compensability and responsibility. In other words, it prohibits denial of the merits of a claim once it has been accepted. In this case, Cigna did not deny compensability of the claim or responsibility of the employer. It denied coverage because it did not provide coverage on the date of injury. Bauman does not apply to invalidate such a denial or bind a carrier to a previous acceptance where there is a lack of coverage."

Thus, as the court stated in Garcia v. SAIF, 108 Or App 653, 658 (1991), "[i]f there is no coverage, there is no basis for payment, and the insurer cannot be held accountable."

However, the rule permitting "back-up" denials for lack of coverage has its own exceptions and limitations. As the court explained in Garcia, the rule only applies where the injured worker's right to receive compensation is not at risk; that is, where the insurers involved have conceded compensability of the claim, and the sole issue is which insurer had the coverage under its contract of insurance with the employer. On the other hand, if the injured worker's right to receive compensation for an accepted claim would be placed at risk to any degree, a "back-up" denial for lack of coverage is simply not to be permitted. Id.

Here, that is the situation. SAIF accepted the claim when it reasonably should have known or determined by its investigation that it did not provide the coverage at the time of the injury. Argonaut, which had the coverage, has denied compensability and responsibility. Claimant's recollection of the circumstances surrounding the injury which occurred many years ago is now less than clear. Thus, to permit SAIF to avoid, for lack of coverage, its liability for the accepted claim would place at substantial risk the right of an injured worker to receive compensation for an accepted claim. Because this battle is not one exclusively between insurance companies, SAIF must be held bound by its acceptance even according to the coverage doctrine that it seeks to apply. For these reasons, SAIF's "back-up" denial must be set aside. Garcia v. SAIF, supra.

Since, even under the rule that SAIF relies on, we conclude that its "back-up" denial must be set aside, we do not reach the question of whether "back-up" denials based on lack of coverage are subject to the limitations of amended ORS 656.262. Furthermore, we also do not reach the merits of Argonaut's denial of compensability and responsibility.

Claimant is entitled to an assessed attorney fee for prevailing over the SAIF Corporation's request for review. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is \$2,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The Referee's order dated March 31, 1992 is affirmed. For his services on review, claimant's counsel is awarded an assessed attorney fee of \$2,000, payable by SAIF.

December 22, 1992

Cite as 44 Van Natta 2491 (1992)

In the Matter of the Compensation of
RODNEY L. WALKER, Claimant
WCB Case No. C2-02619

ORDER ON RECONSIDERATION DISAPPROVING CLAIM DISPOSITION AGREEMENT
Baxter & Associates, Claimant Attorneys
Lundeen et al., Defense Attorneys

On December 9, 1992, the Board received the insurer's request to reconsider the Claim Disposition Agreement approved on November 30, 1992. Specifically, the insurer contended that the agreement was drafted and issued in error, and that, pursuant to an approved Disputed Claim Settlement, the insurer has no accepted claim upon which to base such an agreement.

Having received the insurer's reconsideration request within 10 days of mailing of our final order, we abated our order and requested claimant to submit his position regarding reconsideration. Having received claimant's response, we proceed with our reconsideration.

On reconsideration, claimant agrees with the insurer that the disposition "was improper and issued in error." Claimant also agrees that the disposition should be "set aside."

We agree with claimant and the insurer that the disposition was improper, as a claims disposition agreement may only dispose of an accepted claim. See Frederick M. Peterson, 43 Van Natta 1067 (1991). Consequently, because the parties' disposition attempts to resolve a dispute over a denied claim, we find that it exceeds the bounds of the existing statute and is, therefore, unreasonable as a matter of law. See ORS 656.236(1)(a); Louis R. Anaya, 42 Van Natta 1843 (1990).

Accordingly, on reconsideration, the aforementioned disposition agreement is disapproved.

IT IS SO ORDERED.

December 23, 1992

Cite as 44 Van Natta 2492 (1992)

In the Matter of the Compensation of
GALVIN C. YOAKUM, Claimant
WCB Case No. 91-16041
ORDER ON RECONSIDERATION
Pozzi, et al., Claimant Attorneys
Beers, et al., Defense Attorneys

The insurer requests reconsideration of our December 3, 1992 Order on Review that reversed the Referee's order finding that she lacked jurisdiction to address claimant's contention regarding temporary total disability benefits. Specifically, our order found that, because claimant was objecting to the unilateral termination of his procedural temporary total disability while his claim was in open status, we had jurisdiction to address the matter. Furthermore, we concluded that the insurer did not satisfy ORS 656.268(3) and, therefore, the insurer lacked authority to unilaterally terminate temporary total disability.

In requesting reconsideration, the insurer asserts that the holding in Lebanon Plywood v. Seiber, 113 Or App 651 (1992), is applicable to this case. The insurer contends that, because the order creates the possibility of an overpayment of procedural temporary disability, Seiber may prevent the Board from ordering the procedural temporary total disability award.

In Seiber, the claimant was laid off in April 1988. The employer thereafter accepted an aggravation claim. In May 1988, the claimant's doctor declared him unable to work and then, in November 1988, that he was medically stationary. The claim closed in June 1989 with a permanent disability award; the employer did not pay temporary disability benefits. The Board found that claimant was entitled to temporary total disability benefits from May 1988 through November 1988. However, it further found that claimant was entitled to procedural temporary total disability benefits from May 1988 through June 1989, the date of claim closure. Recognizing that this would create an overpayment, the Board authorized the employer to offset the overpayment against any future permanent disability awards.

The Court of Appeals reversed. It first noted that the employer had not contested the Board's finding that the claimant was substantively entitled to temporary disability benefits from May 1988 through November 1988. However, the court stated that overpayments of procedural temporary disability benefits normally was a consequence of administrative claims processing and not an entitlement. The court found that, if the processing delay did not create an overpayment, the Board had no authority to impose one. 113 Or App at 654.

We find this case distinguishable from Seiber. As our order emphasized, we made no determination regarding claimant's substantive entitlement to temporary total disability benefits, as we lacked jurisdiction to consider such matter. Our order was limited to the legality of the insurer's

unilateral termination of procedural temporary total disability while the claim was in open status. Therefore, we did not impose a requirement on the insurer to pay a greater amount of procedural temporary disability than claimant's substantive entitlement. At most, our order noted that, if the procedural temporary disability award created an overpayment, then an offset could be sought. We do not find that our order's reference to the possibility of an overpayment constitutes the imposition of an overpayment. Therefore, we find Seiber to be inapplicable to this case.

Accordingly, we withdraw our December 3, 1992 order. On reconsideration, as supplemented herein, we adhere to and republish our December 3, 1992 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

December 24, 1992

Cite as 44 Van Natta 2493 (1992)

In the Matter of the Compensation of
HERSCHELL J. CONKLIN, Claimant
WCB Case Nos. 90-20790, 90-17911, 91-02675, 90-16195, 90-17912 & 90-20789
ORDER ON REVIEW
Bennett & Durham, Claimant Attorneys
Davis & Bostwick, Defense Attorneys
Saif Legal Department, Defense Attorneys
Scheminske & Lyons, Defense Attorneys
Schwabe, et al., Defense Attorneys
David O. Horne, Defense Attorney
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Brazeau.

CNA Insurance Company, on behalf of Combustion Engineering, requests review of those portions of Referee Hoguet's order that: (1) set aside its denial of claimant's occupational disease claim for binaural hearing loss; and (2) upheld the SAIF Corporation's denials, on behalf of Oregon Boilerworks and Kipper & Sons Engineers, of the same condition. In its brief, SAIF, on behalf of Oregon Boilerworks, requests a finding that the Assistant Presiding Referee's republication of the Opinion and Order was unnecessary. On review, the issues are propriety of republication of the order and responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee "Findings of Fact," except for his "Ultimate Findings of Fact," with the following supplementation.

FINDING OF ULTIMATE FACT

Oregon Boilerworks was claimant's last Oregon employer prior to his first seeking treatment for his compensable hearing loss condition.

CONCLUSIONS OF LAW AND OPINION

As a threshold matter, we disagree with SAIF's argument that notice of the Referee's order was "unnecessary" to CNA Insurance Company. See Taylor v. Liberty Northwest Insurance Corporation, 107 Or App 107 (1991); Richard F. Taylor, 40 Van Natta 384 (1988); Martin Manning, 40 Van Natta 374 (1988). Consequently, we conclude that the Assistant Presiding Referee properly notified all parties by republishing the Opinion and Order. SAIF's request for a finding to the contrary is denied.

On the merits, we adopt the Referee's "Conclusions and Opinion" from page 3 through the third paragraph on page 4, with the following supplementation.

The issue is whether the Referee properly assigned responsibility to CNA, Combustion Engineering's insurer. The answer depends upon whether Combustion Engineering was the last Oregon employer prior to claimant's first seeking treatment for his compensable hearing loss condition. We conclude that responsibility should be assigned to Oregon Boilerworks, because it, rather than Combustion Engineering, was claimant's last Oregon employer prior to his seeking treatment.

In order to receive Oregon workers' compensation benefits for an injury sustained in another jurisdiction, a worker must be employed in Oregon and become injured while temporarily out of Oregon incidental to the Oregon employment. ORS 656.126(1). In construing ORS 656.126(1), Oregon courts have applied a "permanent employment relation test, wherein all "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 to which the employer is otherwise subject, and the residence of the employees." Northwest Greentree, Inc. v. Cervantes-Ochoa, 113 Or App 186, 189-90 (1992) (citations omitted). The key inquiry is the "extent to which claimant's work outside the state was temporary." Power Master Inc. v. Blanchard, 103 Or 467 (1990); Hobson v. Ore Dressing, Inc., 87 Or App 397, 400, rev den 304 Or 437 (1987). However, in a case such as this, where employees are transient and work in various locations in more than one state, we focus on factors other than the sequence of claimant's temporary work assignments. See Power Master, Inc. v. National Council on Comp. Ins., 109 Or App 296 (1991).

In the present case, claimant is a resident of Oregon. His paychecks from Combustion Engineering were drawn on an Oregon bank and Oregon taxes were withheld. Combustion Engineering has an Oregon address and claimant has worked for this employer previously in Oregon. On the other hand, claimant was hired for this job at the Washington job site and his work was performed and completed in Washington. All supervision occurred in Washington. Claimant had no permanent employment relationship with this employer or any other employer and he had no reasonable expectations of working for Combustion Engineering in Oregon after the Washington job ended.

Under these circumstances, we conclude that claimant's work in Washington was not incidental to Oregon employment. See Roy L. Center, 44 Van Natta 385, 387 (1992). Consequently, Combustion Engineering was not an Oregon employer when it employed claimant in Washington from March 28, 1990 through June 22, 1990. Because Combustion Engineering was not an Oregon employer at the relevant time, responsibility is assigned to the next prior Oregon employer, Oregon Boilerworks, which employed claimant in Oregon from October 12, 1989 through October 20, 1989. See Progress Quarries v. Vaandering, 80 Or App 160, 164-66 (1986).

In addition, SAIF does not argue that claimant's prior employment exposure at Kipper & Sons was the sole cause of claimant's disability or that it was impossible for claimant's employment exposure at Oregon Boilerworks to have caused claimant's disability. Moreover, the medical evidence is to the contrary. Therefore, we find no basis to transfer responsibility from SAIF, on behalf of Oregon Boilerworks, to SAIF, on behalf of Kipper & Sons. See FMC Corporation v. Liberty Mutual Ins. Co., 70 Or App 370 (1984), clarified 73 Or App 223 (1985).

In sum, Oregon Boilerworks is responsible for claimant's compensable hearing loss condition because it was claimant's last Oregon employer prior to claimant's seeking treatment for his occupational disease.

ORDER

The Referee's order dated March 27, 1992 is reversed in part and affirmed in part. That portion of the order that upheld the SAIF Corporation's denial, on behalf of Oregon Boilerworks, is reversed. SAIF's denial is set aside and the claim is remanded to SAIF for further processing in accordance with law. That portion of the order that set aside CNA Insurance Company's denial, on behalf of Combustion Engineering, is reversed and the denial is reinstated and upheld. SAIF (Oregon Boilerworks) shall be responsible for claimant's attorney fee award which the Referee directed CNA to pay. The remainder of the order is affirmed.

In the Matter of the Compensation of
DENISE M. KUPETZ, Claimant
WCB Case No. 91-15751
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Brazeau and Gunn.

The insurer requests review of those portions of Referee Galton's order that: (1) awarded a \$2,250 assessed attorney fee for services concerning the pre-hearing rescission of its denial of claimant's claim for out-of-state medical services; (2) awarded a penalty for allegedly unreasonably delayed and resisted compensation, based on prescription drug and medical mileage reimbursements made on October 22, 1991; and (3) awarded a penalty, or alternatively an attorney fee, for its allegedly unreasonable December 26, 1991 denial, based on "any unpaid and denied out-of-state medical expenses." In its brief, the insurer argues that the Referee erred in denying its motion to dismiss for lack of jurisdiction and objects to the Referee's finding that it conceded that its method of reimbursing claimant was unreasonable. On review, the issues are whether the Referee properly identified the insurer's concession, jurisdiction, penalties and attorney fees. We affirm in part, reverse in part and modify in part.

FINDINGS OF FACT

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

We do not find that the insurer conceded that its payment of benefits by out-of-state checks was unreasonable or that it "thus concedes that this conduct should result in an award of penalties." (O&O p. 2). Instead, we find that the insurer agreed that its method of payment is a "penalty and fee issue." (Tr. 12).

In addition, we find that, although the insurer's payment by out-of-state checks apparently delayed claimant's access to her compensation, reimbursement funds for claimed travel expenses and prescription drugs were available to claimant by November 4, 1991. (See Ex. 28).

Finally, we find, as did the Referee, that the insurer conceded that a penalty was due, based on its late payment of time loss benefits. (See Tr. 6).

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

On this issue, we adopt that portion of the Opinion and Order entitled "Motion to Dismiss," with the following supplementation.

The insurer argues that the Referee lacked jurisdiction over the issues raised by claimant's hearing request, citing Stanley Meyers, 43 Van Natta 2643 (1991). Claimant responds that Meyers is inapplicable. We agree with claimant.

In Meyers, we held that questions concerning the reasonableness and appropriateness of medical services fall outside the jurisdiction of the Hearings Division under amended ORS 656.327. Here, because the insurer's denial of claimant's claim for medical services was rescinded prior to hearing, no jurisdictional issue remained at hearing. Moreover, because the issues remaining at hearing included penalties and attorney fees, the Referee's exercise of jurisdiction was proper. See Russell L. Ragland, 43 Van Natta 1829 (1991); compare Ronald A. Stock, 43 Van Natta 1889 (1991).

Penalties and attorney fees

At the outset, we note that the insurer does not dispute the Referee's penalty assessment which is based on its untimely payment of temporary disability compensation. Rather, the current dispute involves the Referee's assessment of penalties for allegedly unreasonably delayed and resisted

compensation (based on the prescription drug and medical mileage reimbursements paid on October 22, 1991) and for its allegedly unreasonable December 26, 1991 denial (based on "any unpaid and denied out-of-state medical expenses").

A penalty is assessable under ORS 656.262(10) when a carrier "unreasonably delays or unreasonably refuses to pay compensation." The reasonableness of a carrier's denial must be 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); Price v. SAIF, 73 Or App 123, 126 n. 3 (1985). The standard for determining whether a denial is unreasonable is whether the carrier had a legitimate doubt as to its liability for the claim. Brown v. Argonaut Insurance Co., *supra*.

With regard to the first disputed penalty, the insurer argues that its October 22, 1991 reimbursement for prescription drug expenses and medical mileage did not constitute unreasonably delayed or resisted compensation. Because the reimbursed funds were available to claimant within sixty days of the October 4, 1991 claim for reimbursement, (*see* Ex. 19), we do not find that claimant's compensation was unreasonably delayed or resisted. *See* OAR 436-60-070(1). Accordingly, we reverse the penalty which the Referee assessed on this basis.

With regard to the second disputed penalty, we note that the December 26, 1991 denial denied out-of state medical expenses incurred on December 10 and 11, 1991. However, the denial also stated: "Please be advised that any bills that come in will also be denied as you are seeking treatment outside of the State of Oregon." (Ex. 37). In our view, the denial is prospective on its face. As such, it was impermissible and unreasonable under existing law. *See Green Thumb v. Basl*, 106 Or App 98 (1991); Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989).

In addition, we agree with claimant's contention that the denial is unreasonable because it lists no reason for disapproving the claimed out-of-state treatment. *See Safeway Stores, Inc. v. Dupape*, 106 Or App 126 (1991) *rev den* 311 Or 432 (1991). Under these circumstances, we agree with the Referee's assessment of a penalty based on unpaid out-of-state medical expenses. However, we modify the order to exclude the additional attorney fee which the Referee awarded under ORS 656.382(1), as an alternative to the penalty. *See Martinez v. Dallas Nursing Home*, 114 Or App 453 (1992).

The Referee awarded claimant's counsel an assessed attorney fee of \$2,250 for prevailing on a denied claim. The insurer argues that counsel is not entitled to a fee under ORS 656.386(1), because he was not instrumental in obtaining compensation for claimant or, even if he was instrumental, the insurer contends that the fee assessed was excessive.

We find that claimant's counsel, through his request for ongoing service of medical reports and material papers, (*see* Ex. 46), as well as his request for hearing, was instrumental in obtaining compensation for claimant without a hearing. Thus, we conclude that the Referee properly assessed a fee and adopt the portion of the Referee's "Conclusions and Opinion" entitled "(1) Attorneys' Fees." However, inasmuch as the record was largely developed pursuant to claimant's efforts on her own behalf, we agree with the insurer that the \$2,250 assessed was excessive. (*See* Exs. 18, 19, 20, 22, 23, 26, 32, 36). *See Linda M. Akins*, 44 Van Natta 108 (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 fee for claimant's attorney's services prior to hearing concerning the medical services issue 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 the record), the complexity of the issue, and the value to claimant of the interest involved.

Inasmuch as penalties and attorney fees are not compensation for purposes of ORS 656.382(2), claimant is not entitled to a fee for her counsel's efforts on review regarding the penalty and attorney fees issues. *See Saxton v. SAIF*, 80 Or App 631 (1986); Dotson v. Bohemia, 80 Or App 233 (1986).

ORDER

The Referee's order dated March 11, 1992 is reversed in part, modified in part and affirmed in part. That portion of the order that awarded a penalty based on compensation paid by out-of-state

checks is reversed. That portion of the order that awarded an assessed fee under ORS 656.386(1) is modified. For his services which were instrumental in obtaining compensation for claimant without a hearing, claimant's counsel is awarded an assessed fee of \$1,500, to be paid by the insurer, in lieu of the Referee's award. That portion of the order that awarded a penalty based on amounts due under the claim for out-of-state medical services is modified so that no "alternative" attorney fee is awarded under ORS 656.382(1). The remainder of the order is affirmed.

December 24, 1992

Cite as 44 Van Natta 2497 (1992)

In the Matter of the Compensation of
BARBARA A. MILLIGAN, Claimant
WCB Case No. 91-03656
ORDER ON REVIEW
Burt, et al., Claimant Attorneys
Paul L. Roess, Defense Attorney

Reviewed by Board Members Brazeau and Hooton.

Claimant requests review of Referee Garaventa's order which upheld the insurer's denial of claimant's injury claim for traumatic brachial plexopathy. On review, the issues are res judicata and 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 injury claim was not compensable because the preponderance of the medical evidence failed to establish that claimant suffers from traumatic brachial plexopathy. We agree and adopt the order of the Referee in this regard.

However, the Referee also found that the denials, which were upheld by a prior Disputed Claim Settlement (DCS), encompassed the traumatic brachial plexopathy condition. Therefore, the Referee concluded that, even if claimant established that she suffers from traumatic brachial plexopathy, she was now precluded by the doctrine of res judicata from raising the issue. We find that the brachial plexopathy condition was not encompassed within the DCS.

The September 14, 1988 denial, which was resolved by the January 12, 1989 DCS, denied compensability of claimant's "cervical and thoracic problems" and current medical treatment. (Exs. 22-1, 24-3). Citing Dr. Knox's deposition testimony (Ex. 49-9, 49-10), claimant argues that the denial, and thus the DCS, did not encompass the traumatic brachial plexopathy condition because the words "cervical" and "thoracic" refer to specific areas of the spine, whereas brachial plexopathy involves an area of the body distinct from the spine. Claimant further argues that the denial also did not encompass treatment for the brachial plexopathy condition because she was not receiving treatment for that condition in September 1988.

We agree with claimant's arguments. Consequently, we find that claimant's claim was not barred by res judicata. However, for the reasons previously state, we conclude that claimant's claim is not compensable.

ORDER

The Referee's order dated November 13, 1991 is affirmed.

In the Matter of the Compensation of
STEPHEN B. MURPHY, Claimant
WCB Case Nos. 91-07545, 91-02550, 91-03807 & 91-07435
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Susan D. Ebner (Saif), Defense Attorney

Reviewed by Board Members Moller and Brazeau.

Claimant requests review of those portions of Referee Hoguet's order that: (1) upheld the SAIF Corporation's denial of claimant's "new injury" claim for a cervical condition; (2) upheld SAIF's denials of claimant's aggravation claims for his cervical and low back conditions; and (3) found that claimant was entitled to interim compensation based on a wage rate of \$14.77 per hour. On review, the issues are compensability, aggravation, and interim compensation.

Except as modified and supplemented below, we affirm and adopt the Referee's order.

The Referee held that claimant did not sustain a new compensable injury while undergoing a December 1990 physical capacity evaluation in preparation for a possible return to work with his employer. We agree with the Referee's assessment of the medical evidence, which we find supports a conclusion that claimant's neck complaints were attributable to his June 1988 neck injury claim. See Taylor v. Multnomah County School Dist. No. 1, 109 Or App 499 (1991).

We also adopt the Referee's conclusion that claimant's current neck condition does not establish a compensable aggravation of his June 1988 neck claim. Furthermore, in light of our finding that claimant's neck complaints are related to his June 1988 neck claim, it follows that such symptoms do not constitute a worsening of claimant's December 1989 compensable low back claim. Therefore, claimant's aggravation claim regarding his December 1989 low back claim is likewise not compensable.

Finally, the Referee determined that claimant's interim compensation should be paid "at the same rate as his aggravation claim of \$14.77 per hour." We agree with the Referee's ultimate conclusion, but base our holding on the following reasoning.

To begin, we disagree with the Referee's characterization of the December 1989 low back claim as an "aggravation" of apparently either a March 1988 low back claim or a June 1988 neck claim. Inasmuch as a separate claim was filed, accepted, processed, and closed for that injury, it is not an aggravation claim. Thus, the wage rate for the December 1989 claim is not governed by either the March 1988 or June 1988 claim.

In any event, claimant filed his claim for benefits under his June 1988 neck claim and as a "new injury." (Ex 57, 57A, 57B, 59, 60, 62, & 63). Thus, his wage rate under the December 1989 claim is not relevant to our determination.

Claimant's wage rate under his June 1988 claim was \$14.77 per hour. (Ex 23). Noting that his union rate was \$15.91 at the time of his December 1990 "new injury" during the physical capacity evaluation, claimant contends that SAIF was required to pay interim compensation through the date of its denial based on the then-current union rate. We disagree.

A claimant is entitled to temporary disability (in the form of interim compensation) pending acceptance or denial of a claim for a disabling injury if he "leaves work" due to the injury. Bono v. SAIF, 298 Or 405 (1984); Jones v. Emanuel Hospital, 280 Or 147 (1977). If a claimant has been laid off or is not earning wages at the time of his injury, he has not demonstrated that he left work due to the injury and he is not entitled to interim compensation. Ninfa Hernandez, 44 Van Natta 2355 (1992); Donna R. Ruegg, 41 Van Natta 2207 (1989).

Here, claimant was not receiving wages from his former employer at the time of his December 1990 "new injury" during the physical capacity evaluation. Rather, he was receiving unemployment compensation and had been unsuccessfully attempting to secure employment with other employers. The December 1990 evaluation, which was conducted at the request of the employer's physician, was

designed to determine claimant's limitations for available positions. In arranging the evaluation, the physician noted that claimant's job status was "off work until results of PCE." (Ex 35 - 37).

In light of such circumstances, we are unable to find that claimant "left work" as a result of a "new injury" during the December 1990 physical capacity evaluation. (In this regard, we expressly do not adopt those portions of the Referee's order which found that claimant was "in an employed capacity" at the time of the December 1990 evaluation). Thus, SAIF was under no obligation to provide interim compensation under claimant's "new injury" claim. Consequently, it is unnecessary for us to determine the correct wage rate for interim compensation benefits arising from this "new injury" claim.

On the other hand, the record establishes that SAIF received medical verification of claimant's inability to work resulting from a worsening of his compensable neck condition. Therefore, SAIF was obligated to pay interim compensation under claimant's June 1988 neck claim pending its eventual denial of his aggravation claim. See ORS 656.273(6).

Finally, as explained above, claimant's intention in notifying SAIF of the December 1990 event was to either obtain reopening of his June 1988 neck claim or the acceptance of a "new injury" claim. Since he was not seeking the reopening of his December 1989 low back claim at that time, SAIF was under no obligation to provide interim compensation under that claim. Moreover, even if he had sought these benefits, SAIF's duty to pay such compensation would not have been triggered because the medical evidence at the time of the "claim" attributed claimant's inability to work to his June 1988 claim, not the December 1989 claim.

ORDER

The Referee's order dated March 9, 1992 is affirmed.

December 24, 1992

Cite as 44 Van Natta 2499 (1992)

In the Matter of the Compensation of
JAMES M. O'LEARY, Claimant
WCB Case No. 91-17586
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Neidig and Moller.

The insurer requests review of those portions of Referee Thye's order that: (1) found that the Hearings Division had jurisdiction over a dispute concerning the enforcement of a Stipulated Order; and (2) set aside a "de facto" denial of chiropractic treatment. On review, the issues are jurisdiction and medical services.

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

We agree with the Referee's conclusion that this case is similar to Louise A. Greiner, 44 Van Natta 527 (1992). In the present case, the administrative rule cited in the stipulation refers to the frequency and extent of treatment. Former OAR 436-10-040(2)(b). However, the insurer has denied claimant's chiropractic treatment on the ground that, pursuant to the new law, claimant's treating chiropractor, Dr. Harris, is required to make a written request for approval of continuing palliative care.

Under the circumstances, we find this case to be analogous to Greiner, supra, where the employer did not challenge the frequency of claimant's treatment, but rather, denied the treatments on the ground that the new law first required authorization for palliative care from the Director. Accordingly, we agree with the Referee that there is no procedure available in Chapter 656 for resolving this dispute and the Hearings Division has jurisdiction over the enforcement of the stipulated settlement.

Claimant's counsel would normally be entitled to an assessed attorney fee for prevailing against the insurer's request for review. However, because no brief was submitted on Board review, no attorney fee is available. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The Referee's order dated May 8, 1992 is affirmed.

December 24, 1992

Cite as 44 Van Natta 2500 (1992)

In the Matter of the Compensation of
RONALD D. ROBINSON, Claimant
WCB Case No. 91-08084
ORDER ON REVIEW
Gatti, et al., Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of Referee Peterson's order that dismissed claimant's request for hearing without prejudice. On June 26, 1992, we remanded this case to the Referee with instructions to provide an explanation for his decision. Ronald D. Robinson, 44 Van Natta 1232 (1992). Following receipt of the Referee's Interim Order on Remand, the parties were granted an opportunity to submit supplemental briefs. Inasmuch as the time for filing those briefs has expired, we proceed with our review.

Claimant has moved to strike the insurer's reply brief on the ground that the insurer has raised issues not previously raised at hearing or in its appellant's brief. The insurer has moved for a second interim order remanding this matter to the Referee for the admission of Exhibit 64. On review, the issues are motion to strike, remand and whether claimant's request for hearing should have been dismissed with prejudice. We grant claimant's motion to strike, deny the insurer's request for remand and modify the Referee's order.

FINDINGS OF FACT

Claimant requested a hearing on June 20, 1991. Contending that the insurer had failed to pay interim compensation from May 30, 1991 to the time of the request for hearing, claimant sought interim compensation, penalties and attorney fees. On September 13, 1991, claimant filed a supplemental request for hearing, alleging entitlement to interim compensation from May 28, 1991 to the time of the request for hearing, and penalties and attorney fees.

On the date set for hearing, September 23, 1991, neither claimant nor his counsel appeared at hearing. Counsel for the insurer did appear. The Referee informed the insurer's counsel that, approximately one hour prior to the scheduled time for the hearing, claimant's counsel had called "withdrawing his request for hearing."

Counsel for the insurer requested that the Referee dismiss claimant's request for hearing with prejudice. The Referee took the motion under advisement.

Subsequent to the September 23, 1991 hearing, claimant's counsel filed an October 3, 1991 request for hearing on the same issues contained in his September 13, 1991 hearing request.

On October 16, 1991, the Referee dismissed claimant's prior request for hearing on the ground that the request had been withdrawn. The Referee's order did not provide whether the dismissal was granted with or without prejudice.

On October 31, 1991, the insurer requested Board review of the Referee's dismissal order. On June 26, 1992, the Board determined that the Referee's decision would be reviewed for an abuse of discretion. Inasmuch as the Referee had provided no reasoning concerning the decision to dismiss, the Board remanded the matter to the Referee for an explanation.

On August 18, 1992, the Referee issued an Interim Order on Remand. Stating that it was his usual practice to issue dismissal orders without a reference to "with prejudice," the Referee reasoned

that it would be unfair to deviate from that procedure particularly when claimant was unaware of the insurer's motion to dismiss with prejudice.

CONCLUSIONS OF LAW AND OPINION

Motion to strike

The issue for our determination is whether it was an abuse of discretion for the Referee to dismiss claimant's hearing request without prejudice. In reaching this determination, we have considered the parties' appellate briefs to the extent that they address this issue based on the record developed at the hearing. To the degree that either brief divurges into a discussion of speculation, innuendos, and so-called "false representations," those comments have not been considered.

Remand

The insurer moves for a second order remanding this matter to the Referee to admit evidence regarding a second request for hearing filed by claimant. Inasmuch as we have taken administrative notice of the October 3, 1991 hearing request, it is unnecessary for us to remand this case to the Referee. See Susan K. Teeters, 40 Van Natta 1115 (1988). (Official notice may be taken 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). Such a fact is the filing of a hearing request.)

Order of dismissal

Unless otherwise agreed among the parties and the Referee, pre or post hearing motions shall be filed in writing and copies shall be simultaneously served on all parties or their attorneys. OAR 438-06-045. Unless otherwise ordered by a Referee, ten days after filing of the motion shall be allowed for a written response to the motion. Id.

Here, because claimant had orally withdrawn his hearing request the day of the hearing, the insurer's motion was not presented in written form. Rather, since the insurer was present at the scheduled time for the hearing when claimant's withdrawal was announced, its counsel presented the motion to dismiss with prejudice on the record. Since claimant had withdrawn the hearing request, the proceeding in which the Referee received the insurer's motion was not a hearing. Instead, the Referee merely was developing a record to document the insurer's motion and its argument in support of the motion.

Nevertheless, since claimant had no notice of the motion to dismiss with prejudice and the Referee did not otherwise schedule a time for claimant to respond, claimant was entitled to a ten-day notice within which to present his position regarding the insurer's motion. Thus, it was an abuse of discretion for the Referee to issue a dismissal order without first permitting claimant an opportunity to respond to the insurer's request. However, because the Referee ruled in claimant's favor, claimant was not aggrieved by the Referee's failure to comply with OAR 438-06-045. Moreover, since claimant had an opportunity to submit his position prior to the issuance of the Referee's Interim Order on Remand, any violation of the rule has now been cured.

On remand, the Referee provided the following reasoning for the dismissal of claimant's hearing request without prejudice:

"Upon consideration, I concluded that it would be unfair to issue a dismissal order in any other form than the one I always use because this is the form that all claimants anticipate when they withdraw their request for hearing. Here, the claimant was not aware that the employer requested that I deviate from my customary procedure and dismiss with prejudice. This system depends upon precedent and uniformity. Accordingly, on October 16, 1991, I issued the dismissal order in my usual and customary format (dismissed without prejudice)."

We have previously concluded that the Referee has discretion to set the terms and conditions of an order of dismissal as he or she deems proper. Julie Mayfield, 42 Van Natta 871 (1990). In Mayfield, we concluded that we will not disturb the terms and conditions imposed by the Referee except upon a showing of abuse of discretion. Additionally, in Roger D. Estep, 43 Van Natta 196 (1991), we concluded that, where claimant withdrew his request for hearing and the employer did not raise, argue or move for an order of dismissal with prejudice, the Referee had discretion to dismiss the request for hearing

and to set the terms and conditions of the order. In Estep, supra, we found no abuse of discretion by the Referee with regard to the order of dismissal without prejudice.

Here, unlike the carrier in Estep, the insurer expressly moved for an order of dismissal with prejudice. In response to the insurer's motion, claimant asserts that, because he withdrew his hearing request, the request must be dismissed without prejudice. After consideration of these positions, the Referee concluded that it would be unfair to claimant to deviate from his customary procedure of dismissing withdrawn hearing requests without prejudice.

After conducting our review under the relevant standard, we hold that it was an abuse of discretion for the Referee to dismiss claimant's hearing request without prejudice. Specifically, we do not consider the Referee's reliance on a "customary procedure" to be a sufficient explanation for denying the insurer's motion to dismiss a hearing request with prejudice when that hearing request was withdrawn by means of a telephone call from claimant's counsel approximately one hour prior to the scheduled convening of that hearing. Claimant's response that he is entitled to withdraw his hearing request begs the question. Yes, claimant is certainly entitled to withdraw his hearing request. However, whether that hearing request will be dismissed with or without prejudice is a matter solely subject to the discretion of the Referee.

In light of the circumstances presented in this particular case, we can reach no other conclusion than the Referee abused his discretion in dismissing claimant's hearing request without prejudice. In reaching this decision, we find guidance from the following principles. Since the triggering event for the scheduling of any hearing is the hearing request itself, the filing party holds the key to the initiation of the process. Thus, a basic tenet upon which the hearing process must be based is that, upon the filing of a hearing request, the filing party will be prepared to present their case at the forthcoming hearing. This underlying principle is particularly applicable in cases such as this one, where no statutory time limits apparently apply.

Without question, claimant may withdraw his hearing request, prompting the dismissal of the request. Moreover, as demonstrated by Estep, when no objection is raised by the other party, a hearing request may be dismissed without prejudice. In fact, there are undoubtedly circumstances where a claimant could provide a sufficient explanation regarding why a particular hearing request should be dismissed without prejudice. However, when an objection is raised to a dismissal without prejudice, it is necessarily incumbent on claimant (as the party who requested the hearing) to provide an explanation for the withdrawal. This is particularly important where, as here, the hearing request is withdrawn by means of a phone call an hour before the scheduled hearing and a hearing request raising the same issues is filed some 10 days later.

An affirmance of this Referee's dismissal without prejudice could be construed as permitting the "de facto" granting of a postponement or continuance of claimant's initial hearing request. This is a message which we most definitely do not wish to send to parties, practitioners, and the Hearings Division. If a party desires a postponement or continuance of a scheduled hearing, our rules specify the appropriate procedures that must be followed. See OAR 438-06-081; 438-06-091. If a party cannot satisfy those requirements, that party should not be allowed to bypass those procedures by obtaining a dismissal without prejudice and then subsequently filing a new request for hearing on the same issues. Such practices would only delay litigation, encourage a lack of preparation, and prejudice the opposing party who has prepared for hearing.

In reaching this conclusion, we wish to emphasize that we are not accusing claimant of either seeking or obtaining a "de facto" postponement of his hearing. Rather, we are finding that, in light of claimant's explanation for the withdrawal of his hearing request in response to the insurer's motion for a dismissal order with prejudice, it was an abuse of discretion for the Referee to dismiss claimant's hearing request without prejudice. Accordingly, we modify the Referee's Order of Dismissal to dismiss claimant's hearing request with prejudice.

ORDER

The Referee's October 16, 1991 Order of Dismissal is modified to dismiss claimant's request for hearing with prejudice.

In the Matter of the Compensation of
ESTEVAN LARA, Claimant
WCB Case No. 92-01711
ORDER ON REVIEW
Emerson Fisher, Claimant Attorney
Kenneth Russell (Saif), Defense Attorney

Reviewed by Board Members Moller and Brazeau.

The SAIF Corporation requests review of Referee Peterson's order that set aside its denial of claimant's aggravation claim for his current disc herniation at L5-S1. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

After July 1, 1987, SAIF was no longer the insurer for claimant's employer.

CONCLUSIONS OF LAW AND OPINION

The Referee found that claimant's disc herniation at L5-S1 was a primary consequence of the March 25, 1986 industrial injury. He concluded that, because claimant's injury was a material contributing cause of his disc herniation, his condition was compensable. We disagree.

Here, the only medical opinion regarding causation of claimant's condition is provided by Dr. Bergquist, claimant's treating physician. Dr. Bergquist has opined that causal factors contributing to claimant's disc herniation include the 1986 injury and degenerative disc disease or deterioration. Although some of the factors may have impacted claimant's back over a period of several years, there is no indication that claimant had a preexisting degenerative condition within the meaning of ORS 656.005(7)(a)(B). In the absence of such evidence, there is no "resultant condition" and ORS 656.005(7)(a)(B) is inapplicable. See Marie M. Sax, 44 Van Natta 2152 (1992).

On the other hand, the medical evidence establishes the development of claimant's disc degeneration or deterioration since the compensable injury. (Ex. 5, Ex. 11). Dr. Bergquist's uncontradicted diagnosis establishes that claimant currently suffers from a ruptured disc and disc deterioration. (Ex. 22). However, it is undisputed that the ruptured disc is due in part to post-injury disc deterioration. (Ex. 21). Under these circumstances, claimant must establish that his current condition arose as a consequence of his compensable 1986 injury. ORS 656.005(7)(a)(A); Marie M. Sax, supra. Thus, he must prove that his 1986 injury is the major contributing cause of the allegedly consequential disc rupture at L5-S1. See Julie K. Gasperino, 43 Van Natta 1151 (1991), aff'd Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

Here, claimant's diagnosis following the March 1986 injury was lumbar sprain/strain. That condition was accepted by SAIF. In October 1986, a CT scan showed that claimant had a minimal disc bulge at L5-S1, moderate disc protrusion at L4-5, a mild bulging annulus at L3-4, and no other significant changes. (Ex. 5).

Claimant continued to receive occasional treatment for his low back condition from 1987 through 1990. On September 4, 1991, chart notes from the Maple Street Clinic reported that claimant had "continuing low back pain but now having radiculopathy and weakness on his right leg." The Clinic diagnosed lumbar back pain with radiculopathy and weakness on the right side indicating a ruptured disc at L5-S1. (Ex. 6-5). A subsequent MRI showed "a large herniation in L5-S1 consistent with his physical findings." (Ex. 6-6).

On December 30, 1991, claimant's treating surgeon, Dr. Bergquist, M.D., reported that claimant suffered the L5-S1 herniation near the beginning of November 1991. He later clarified his report and opined that his original consultation actually reflected that claimant suffered the disc herniation around the "beginning of September 1991." (Ex. 22).

In December 1991, Dr. Bergquist reported that the major contributing cause of claimant's L5-S1 disc herniation was degenerative disc disease, the cause of which is "essentially unknown."

On March 16, 1992, Dr. Bergquist stated that the pain that claimant was having all along was related to a disc abnormality at L5-S1, and it was likely that the pain claimant had experienced was related to the disc which eventually ruptured. However, Dr. Bergquist stated that the "injury that (claimant) had in 1986 certainly did not cause the disc rupture which occurred in 1991." Dr. Bergquist believed that the injury was a material contributing factor to claimant's disc deterioration, but "[t]he major contributing cause to his disc herniation which he suffered in 1991 was certainly not the injury which occurred in 1986." (Ex. 21).

On March 20, 1992, Dr. Bergquist corrected his prior report and stated that claimant suffered his herniation around the beginning of September 1991. He stated that the injury "probably was a material contributing factor to his disc herniation." However, Dr. Bergquist stated that other factors contributed to the deterioration of the disc and he reiterated that the "major contributing cause to his disc herniation which he suffered in 1991 was certainly not the injury which occurred in 1986." (Ex. 22).

We conclude that the medical evidence supports a finding that claimant's disc herniation was caused by his degenerative disc deterioration. Claimant has failed to establish that the 1986 injury was the major cause of his L5-S1 disc herniation in 1991. There is no medical evidence to the contrary.

Accordingly, we find that claimant's disc herniation is not compensable and we reverse the Referee on the issue of compensability. The Referee's attorney fee award is also reversed.

ORDER

The Referee's order dated May 1, 1992 is reversed. The SAIF Corporation's denial of January 20, 1992 is reinstated and upheld. The Referee's attorney fee award of \$2,500 is also reversed.

December 14, 1992

Cite as 44 Van Natta 2504 (1992)

In the Matter of the Compensation of
CYNTHIA A. POGUE, Claimant
WCB Case No. 91-12779
ORDER ON REVIEW
Schneider & DeNorch, Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of those portions of Referee Bethlahmy's order that: (1) found that the SAIF Corporation's failure to pre-authorize surgery did not constitute a "de facto" denial of medical services; and (2) declined to award an assessed attorney fee for an allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees.

We affirm and adopt the Referee's order.

ORDER

The Referee's order dated January 10, 1992 is affirmed.

In the Matter of the Compensation of
CECILIA A. WAHL, Claimant
WCB Case No. 91-18422
ORDER ON RECONSIDERATION
Flaxel, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Claimant requests reconsideration of our November 30, 1992 Order on Review that upheld the SAIF Corporation's partial denial of claimant's current cervical condition. Claimant argues that we did not address her argument that SAIF accepted both her cervical injury and her preexisting cervical condition. We do not find that the record supports claimant's contention that SAIF accepted her underlying cervical condition as well as the cervical injury.

In support of her contention, claimant cites Richard R. Zippi, 44 Van Natta 1278 (1992). That case is inapposite. In Zippi, we applied Georgia-Pacific v. Piwowar, 305 Or 494 (1988), in which the court held that by accepting the symptoms of the underlying disease, the insurer was thereafter precluded from denying the compensability of the underlying condition "regardless of the cause." We found that the insurer's acceptance of the claimant's claim for "excessive pain [in both feet] while standing on the job" constituted an acceptance of the subsequently identified underlying condition of flat feet. Zippi, supra at 1279. In other words, the insurer accepted symptoms of claimant's underlying disease; therefore, it could not later deny compensability of his preexisting condition, regardless of the cause. Id.

Here, however, SAIF did not accept symptoms of claimant's preexisting cervical condition. The acceptance did not list the conditions accepted. (Ex. 1). However, contemporaneous medical reports indicated that claimant suffered a neck strain/sprain. (Exs. 3, 4b-1). Furthermore, a stipulation noted that the claim for "injury to [claimant's] neck, back, and both knees sustained on or about December 5, 1986" was accepted. (Ex. 9).

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). SAIF did not specifically or officially accept claimant's preexisting cervical condition in writing. Also, on this record, we do not find that SAIF accepted the symptoms of claimant's preexisting cervical condition. Therefore, the holding in Piwowar, supra, does not apply here.

Claimant also speculates that her past awards for unscheduled permanent partial disability must have included amounts related to claimant's limitation due to her preexisting cervical condition. To the extent that this is an assertion that payment of these awards constituted an acceptance of the preexisting cervical condition, we note that merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability. ORS 656.262(9).

Accordingly, we withdraw our November 30, 1992 order, On reconsideration, as supplemented herein, we adhere to our November 30, 1992 order in its entirety. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
GARY D. GALLINO, Claimant
WCB Case No. 91-07125
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by the Board en banc.¹

The SAIF Corporation requests review of that portion of Referee Howell's order that directed it to pay claimant's scheduled permanent partial disability award at the rate of \$305 per degree. Claimant cross-requests review of that portion of the order denying his request that the issue of the extent of scheduled permanent disability be remanded to the Director for adoption of temporary rules amending the standards. On review, the issues are rate of scheduled disability, authority of the Hearings Division and the Board to remand an order on reconsideration to the Director for implementation of the provisions of ORS 656.726(3)(f)(C), and applicability of amended OAR 436-35-230 for purposes of rating extent of claimant's permanent disability. We reverse in part, affirm in part, and affirm the Notice of Closure.

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), where 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, supra.

In this case, claimant was injured before May 7, 1990. Accordingly, amended ORS 656.214(2) does not apply. 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).

Adoption of Temporary Rule

We agree with the Referee's interpretation of ORS 656.726(3)(f)(C) as reserving to the Director the authority to make findings as to whether or not the worker's disability is addressed by the standards and, if not, to stay further proceedings and adopt temporary rules amending the standards to accommodate the worker's impairment. We also agree with his conclusion that, consequently, neither the Hearings Division nor the Board has authority to remand an order on reconsideration to the Director for implementation of the provisions of ORS 656.726(3)(f)(C). The Referee based this conclusion on the language of the statute and legislative history. The Referee reasoned:

"The provisions of ORS 656.726(3)(f)(C) are expressly limited to those situations '(W)hen, on reconsideration, * * * it is found that the worker's disability is not addressed by the standards[.]' There is no provision for the adoption of temporary rules to accommodate a worker's impairment when, at hearing, it is found that the 'standards' do not address that worker's disability.

"To the extent that it might be argued that ORS 656.726(3)(f)(C) is ambiguous, legislative history supports the interpretation argued by SAIF.

¹ Because he was the attorney of record, Member Hooton has not participated in this review. OAR 438-11-623.

"During debates on the floor of the House, Representative Shiprack explained that portion of SB 1197, § 40 which became ORS 656.726(3)(f)(C). He said:

'In Section 40 a very important change that we have argued on this floor vehemently over the years, and I want to say I'm very happy that we came up with the language in this section. This has to do with standards for rating disabilities. [* * *] It's a feeling or a perception on some people, probably correct in a few places, that [* * *] the standards for rating disabilities do not adequately address in a handful of cases the true impairment that an individual suffers. What we're going to do here is at the Evaluations level, should a worker (sic) find that his or her impairment is not covered by the standards, the claim is stayed, the Director shall look at that claim, look at the medical evidence, and issue an emergency rule so that that individual can get their money that is appropriate for that individual's impairment. . . .'

House Floor Debate on SB 1197, Special Session, May 7, 1990.

"Senator Shoemaker made the same point even more clearly during Floor debates of SB 1197 in the Senate. The Senator said;

'If the Director finds that the standards don't appropriately apply to a particular injury, the Director will suspend further proceedings and will then adopt, and this is mandatory, shall adopt a temporary rule which develops a new standard to apply to that particular injury. So when you have an injury that doesn't fit within the standards, a new standard is developed within the Director's office, and applied to that injury.

' * * *

'So this process that I've just described allows a worker's particular disability to be adequately addressed within the administrative framework of the Department, and without getting into litigation. It provides a return to the subject at least once through an independent panel of doctors, and provides a way to depart from the standards when that is appropriate.

'If after all that, the worker is still not satisfied that his impairment and his disability has been properly addressed, he then may appeal and go up to the Referee, Workers' Compensation Board, and into the courts just as they do now. . . . (emphasis added)

"Floor Debate on SB 1197, Senate Special Session, May 7, 1990.

"The Order on Reconsideration in this case made no findings as to whether the applicable "standards" addressed claimant's disability. Absent such a finding, the procedure for the adoption of temporary rules in ORS 656.726(3)(f)(C) does not apply. Furthermore, even though the statutory procedure may be mandatory, as Senator Shoemaker indicated during the Special Session, neither the Board nor its Referees have authority to compel the Department to make findings as to whether or not the "standards" address claimant's disability. Therefore, claimant's request to remand to the Director for implementation of the provisions of ORS 656.726(3)(f)(C) must be denied."

We agree with and adopt the Referee's well-reasoned conclusions on this issue. In addition, we find further support for the Referee's construction of the statute in the legislature's intent to charge only the Director with the duty of enacting standards for the evaluation of disability. In this regard, under ORS 656.726(3)(f), the Director may provide standards for the evaluation of disability. When evaluation of disability is by the referee or Board, both bodies "shall apply * * * such standards for evaluation as may be adopted by the director pursuant to ORS 656.726." ORS 656.283(7), 656.295(5). Moreover, the parties are not prevented or limited from establishing "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." *Id.* We find that these statutes evidence an intent to invest the Director with the exclusive authority to enact standards for evaluating a worker's disability.

Particularly when reviewing an order on reconsideration, the Hearings Division and the Board are charged only with the power to apply those standards. The statutes contain no indication that the Hearings Division and the Board have authority to provide standards or require the Director to enact rules for evaluating disability.

Based on the above statutes, we are further persuaded that the legislature intended to charge only the Director with the responsibility to determine on reconsideration whether a worker's disability is addressed by the standards. Were we to conclude that the Hearings Division and Board had authority to make such a finding and remand an order on reconsideration to the Director to enact temporary rules, we would not be complying with the legislature's intent that we only apply standards and would be usurping the Director's exclusive power to enact standards.

Therefore, we conclude that we lack authority to remand to the Director for a finding that claimant's disability, which he alleges is due to a chondromalacia condition, is not addressed by the standards and for the adoption of temporary rules to accommodate such an impairment.

Extent of scheduled disability

At hearing, claimant contested the Order on Reconsideration, which affirmed an award of 5 percent scheduled permanent disability as awarded by Notice of Closure. Although we have above concluded that we have no authority to remand cases to the Director for the adoption of temporary rules where the standards fail to provide for certain impairment, the Director has recently promulgated a rule providing for an impairment award for chondromalacia. Because the issue of claimant's impairment is before us on review, we address the applicability of the rule in the present case.²

The Department's temporary rule, effective June 1, 1992, found that, in cases involving Grade IV chondromalacia and/or secondary strength loss or effusion, a rule was necessary in order to provide for a value in rating disability as such disability had not been addressed by the standards. Accordingly, the Department amended OAR 436-35-230 to provide for such an award.³

In regard to the applicability of the rule to the standards themselves, the Department also amended OAR 436-35-003. The amended rule now provides, in pertinent part:

"(1) These rules apply to the rating of permanent disability pursuant to chapter 656 and shall be applied to all claims closed on or after the effective date of these rules for workers medically stationary prior to July 1, 1990. For workers medically stationary prior to July 1, 1990, Administrative Order 6-1988 shall apply to the rating of permanent disability.

"(2) For claims in which the worker was medically stationary after July 1, 1990 and a request for reconsideration has been made pursuant to ORS 656.268, disability rating standards in effect on the date of issuance of the Determination Order or Notice of Closure and any relevant temporary rules adopted pursuant to ORS 656.726(3)(f)(C) shall apply."

In the present case, claimant was medically stationary after July 1, 1990 and a request for reconsideration was made pursuant to ORS 656.268. Accordingly, pursuant to OAR 436-35-003(2), the standards in effect on December 21, 1990, the date of the Notice of Closure, in addition to the relevant

² Here, the Referee found, and we agree, that because claimant objected to the application of the impairment findings rather than the actual findings themselves, the appointment of an arbiter pursuant to ORS 656.268(7) was not required. Accordingly, we find that the reconsideration order was valid and we have jurisdiction to address claimant's cross-request for review. See Doris C. Carter, 44 Van Natta 769 (1992); Carl Smith, 44 Van Natta 1175 (1992).

³ We note that the Department's temporary rules, former OAR 436-35-008 and former OAR 436-35-230, expired November 27, 1992. The Department's permanent rules were adopted effective November 27, 1992. WCD Admin. Order No. 17-1992.

temporary rule, OAR 436-35-230(13), apply to the rating of claimant's permanent disability. See also OAR 438-10-010.⁴

Because we find that the record concerning the extent of scheduled disability is fully developed, we proceed to rate extent of claimant's scheduled permanent disability. As noted in claimant's brief, because there was no arbiter appointed in this case, we use the impairment findings of claimant's treating physician to rate disability. ORS 656.245(3)(b)(B); Dennis E. Connor, 43 Van Natta 2799 (1992)(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).

As amended, OAR 436-35-230 now provides for a value for chondromalacia and degenerative joint disease of the knee. The rule provides that:

"(13)(a) Except as provided in subsection (b) of this section: for chondromalacia, arthritis, or degenerative joint disease of the knee, the rating shall be determined pursuant to the chronic condition rule, if the criteria of OAR 436-35-010(6) are met.

"(b) A value of 5% of the leg shall be combined with other impairment values, including chronic condition as in (a) above, if there is diagnosis of more extensive chondromalacia, arthritis, or degenerative joint disease and one or more of the following:

- "(A) Grade IV Chondromalacia;
- "(B) Secondary Strength Loss;
- "(C) Chronic Effusion; or,
- "(D) Varus or valgus deformity less than that specified in subsection (4) of this rule."

OAR 436-35-230(13)(a)-(b).

Here, Dr. Freudenberg, M.D., claimant's treating physician, found that, following claimant's left knee injury, arthroscopic surgery showed that he had grade II chondromalacia of the left knee. Finally, although Dr. Freudenberg found no effusion, he agreed with the physical therapist's finding regarding claimant's leg weakness and knee pain. Ex. 7.

Accordingly, because claimant has grade II chondromalacia, we disagree that he is entitled to an award pursuant to OAR 436-35-230(13)(b)(A), which only provides an award for grade IV chondromalacia. However, we conclude that claimant is entitled to a 5 percent award for degenerative joint disease as evidenced by secondary strength loss. OAR 436-35-230(13)(b)(B).

Finally, although there is evidence of a chronic condition limiting repetitive use of the knee, the standards in effect at the time of the Notice of Closure provide that, where impairment in a body part is equal to or in excess of 5 percent, the worker is not entitled to any scheduled chronic condition impairment. Former OAR 436-35-010(8)(a). Consequently, claimant's total impairment for his left knee condition is 5 percent. Therefore, under the "standards," claimant's scheduled permanent disability award remains 5 percent. On review, we affirm the Notice of Closure award of 5 percent scheduled permanent disability.

⁴ As of June 25, 1992, the Board amended its rule regarding the effective date for applying the standards, in order to insure that the Department's standards are applied consistently and uniformly at all levels of review. The Board's rule became permanent effective December 14, 1992.

OAR 438-10-010 now provides that:

"In applying the disability rating standards at hearing and on review, the referee and the Board shall apply the disability rating standards as required by OAR 436-35-003.

ORDER

The Referee's order dated September 10, 1991 is reversed in part and affirmed in part. That portion of the Referee's order that directed the SAIF Corporation to pay claimant's scheduled permanent disability at the rate of \$305 per degree is reversed. SAIF is directed to pay claimant's scheduled permanent disability award at the rate in effect on the date of injury. The Notice of Closure, as affirmed by the Order on Reconsideration, is affirmed. The remainder of the Referee's order is affirmed.

Board Member Gunn dissenting.

Whenever this body is compelled to deal with the Director's authority, particularly as it relates to the reconsideration process, we seem to adopt that reasoning so eloquently expressed by Joseph Heller in the novel, Catch 22:

"Orr would be crazy to fly more missions and sane if he didn't, but if he was sane he had to fly them. If he flew them he was crazy and didn't have to; but if he didn't want to he was sane and had to. Yossarian was moved very deeply by the absolute simplicity of the clause of Catch 22 and let out a respectful whistle. 'That's some catch, that Catch 22.'"

The character Orr avoids Catch 22 by rowing to Sweden. I, on the other hand, do not have that option. Although I am sure the majority would gladly lend me the boat and oars.

In the instant case, I must disagree with the majority's conclusions and the Opinion and Order of the respected Referee John Howell. I base my dissent on a narrow reading of the statute in question. I also believe that reading is supported by the legislative history relied upon by the majority and Referee Howell.

First, the one issue that we do have an answer for is whether claimant's disability (chondromalacia) is addressed by the standards adopted. The adoption in June 1992 of a temporary rule by the Director to include chondromalacia answers that question.

Next, I find that a plain reading of ORS 656.726(3)(f)(C) should have compelled the adoption of a rule regarding claimant's chondromalacia in May 1991, at the time of his reconsideration. Specifically, the statute provides that a temporary rule shall be adopted to accommodate a workers impairment "when, upon reconsideration of a determination order or notice of closure pursuant to ORS 656.268, it is found that the worker's disability is not addressed by the standards . . ." Therefore, unlike the Referee and the majority, I do not believe the rulemaking process is compelled solely by a finding by the Director.

Here, at closure, the treating physician identified the impairment and found the "it" referred to in ORS 656.726(3)(f)(C), i.e., a disability that was not addressed by the standards. Thus, that should be enough to trigger an adoption of the necessary rule.

Such a conclusion is consistent with legislative history and with the actual words of Representative Shiprack (one of the drafters of SB 1197) who stated that:

"should a worker find that his or her impairment is not covered by the standards, the claim is stayed, the Director shall look at that claim . . . and issue an emergency rule so that individual can get their money that is appropriate for that individual's impairment."

Those clear words state the two central purposes for the legislative changes that were made: (1) the rulemaking action was intended to be triggered by findings of an impairment not covered by the standards, but not restricted to only findings by the Director; and (2) the provision was intended to provide claimants with all benefits due to them by taking into consideration specific impairments. With that in mind, the majority and Referee's end result takes a wide berth without nearing the legislative purposes behind the statute.

Additionally, the attending physician found that claimant had impairment not addressed by the standards.¹ Therefore, on reconsideration, the Director should have made some finding that claimant's condition was or was not covered by the standards. Since impairment findings were in dispute, at the very least, the Director should have appointed a medical arbiter (or if requested by the parties, a panel) to review the disputed impairment issue. See ORS 656.268(7). This is consistent with Representative Shiprack's legislative comments:

"So this [reconsideration] process that I've just described allows a worker's particular disability to be adequately addressed within the administrative framework of the Department and without getting into litigation. It provides a return to the subject at least once through an independent panel of doctors, and provides a way to depart from the standards when that is appropriate".

The medical arbiter process is the only way the Director could escape the clear mandatory language of 656.726(3)(f)(C) which reads: "[T]he Director shall stay further proceedings on the reconsideration of the claim and shall adopt temporary rules amending the standards to accommodate the worker's impairment."

Under the majority's holding unless the Director happens to raise the issue or stumble across it on reconsideration, the Director has no obligation to suspend reconsideration and publish a new rule. If the purpose of the change was to remove such disputes from litigation, the majority's holding only provides resolution of these issues by mandamus actions through the courts to compel Director action. That is expressly against the legislative intent to address workers' particular disabilities "without getting into litigation."

Moreover, I am unable to distinguish on this record why this case differs from others where we have applied the mandatory "shall." In the instant case, the dispute is over impairment. Further, 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. Therefore, we should have invalidated the order as consistent with other cases where 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, recon den 44 Van Natta 1609 (1992).

In sum, the law stands clear and firm: the Director is mandated to adopt a temporary rule to accommodate a worker's impairment when it is found that the worker's disability is not addressed by the standards. That is the case here.

Simply put, we have a law. The law says we are to apply the law. So we should do just that: apply the law.

The final bit of irony is that the majority does apply the rule which provides for the disability of chondromalacia to claimant in the present case. But the "Catch 22" here is that the rule does not apply to claimant's grade of chondromalacia. Further, even if the grade IV chondromalacia rule were applicable to claimant's grade II chondromalacia, claimant still would not receive permanent disability benefits for his condition. He has already received 5 percent permanent disability and he now cannot receive further benefits for his chronic condition.²

The end result is that we have a claimant who should have had a rule back in May 1991. He does not get such a rule. Yet, we apply a June 1992 rule that was adopted to address claimant's type of disability. However, its application has the same effect as having no rule, for it provides nothing.

¹ On reconsideration, claimant's request identified as a specific issue that claimant's impairment was not addressed by the standards. In the reconsideration order, it appears that the Department failed to recognize that Dr. Freudenberg was the treating physician at the time of claim closure. See "Finding of Fact" in Referee Howell's Opinion and Order. The Department discounted Dr. Freudenberg's opinions on the ground that he was not claimant's attending physician.

That's some law, that ORS 656.726(3)(f)(C).

² Of note, the Director in enacting the grade IV chondromalacia rule failed to apply the American Medical Association (AMA) guidelines as required in the evaluation of impairment. See OAR 436-35-005(15) and OAR 436-35-007(4). The Director's rule provides a value of 5 percent impairment for grade IV chondromalacia. See OAR 436-35-230(b)(A). However, the AMA guidelines provide that the disorder of chondromalacia in general equates to an impairment of 0-20 percent, according to deformity. See Guides to the Evaluation of Permanent Impairment 68 (3d ed revised 1990).

Board Member Kinsley concurring in part and dissenting in part.

I concur with the majority's conclusion that claimant's award must be paid at the rate in effect on the date of injury. SAIF v. Herron, 114 Or App 64 (1992).

I disagree that the Referee and this Board have no authority to remand a case to the Department of Insurance and Finance (DIF) in order to carry out the mandatory rule making provisions of ORS 656.726(3)(f)(C).¹

I further disagree with the award of 5 percent scheduled permanent partial disability for loss of use and function of claimant's left leg (knee).

A. Authority to Remand for Disability Rating Rule Making

Here, we have a worker who has disability due to grade II chondromalacia of the left lateral femoral condyle that is related to a compensable claim. However, neither at the time the Notice of Closure was issued in December 1990 nor at the time the DIF Order on Reconsideration was published in May 1991, was there any specifically applicable rule promulgated by DIF to compensate for that condition. Even though the rules covering rating of permanent disability have resulted in thicker and thicker books of rules over the years, there is still the occasional medical condition that results in disability that is not addressed by those rules. This is not surprising, given the many ways that individual bodies and minds can react to the many kinds of injuries and diseases.

Prior to the adoption of ORS 656.726(3)(f)(C) in 1990, when a referee or the Board came across a case where there was no DIF rule to cover an individual worker's disability, the award was corrected by the referee or Board by adding an amount to the worker's award commensurate with the proven loss. In reviewing this prior process, the 1990 Legislature enacted ORS 656.726(3)(f)(C), apparently trying to provide an earlier opportunity to correct the award at the DIF level so that the parties would not have to undergo the delay and expense of further litigation before determination of the correct award. In other words, it appears the legislature created a procedure that would cause DIF's disability rating standards to be as comprehensive as possible so that the proper amount could be awarded in the first instance. This makes sense to me and, I believe, was a laudable goal.

The problem presented by this case is, when that goal has not been met by DIF, what remedy does a party have to correct the inadequate award for the worker's permanent disability? If a party is unable to convince DIF to publish a rule covering the worker's disability, must the party go to the further expense and delay of requesting a writ of mandamus through circuit court seeking an order requiring DIF to publish a rule? The legislature has already created a comprehensive appeal and review system for dispute resolution in workers' compensation matters that, on purpose, avoids having to

¹ ORS 656.726(3)(f)(C) reads:

"When, upon reconsideration of a determination order or notice of closure pursuant to ORS 656.268, it is found that the worker's disability is not addressed by the standards adopted pursuant to this paragraph, notwithstanding ORS 656.268, the director shall stay further proceedings on the reconsideration of the claim and shall adopt temporary rules amending the standards to accommodate the worker's impairment. When the director adopts temporary rules amending the standards, the director shall submit those temporary rules to the Workers' Compensation Management-Labor Advisory Committee for review at their next meeting.

depend on our overburdened circuit courts. However, the result of the majority opinion will be to send these matters to circuit court judges to decide whether a particular disability was covered by DIF's rules and determine if remand to DIF for rulemaking is appropriate. With all due respect to the circuit court judges of this State, I believe the expertise to make that judgment rests in the workers' compensation referees and this Board. The applicable statutes can and should be interpreted to allow us to fill that role in an appeal system that already handles review of awards for disability. An alternative appeal procedure, but one that is lengthy and expensive, is to require the parties to make two meaningless appeals to a referee and the Board (as here) before the case can progress to the Court of Appeals so the Court, pursuant to ORS 183.482(8), can decide whether to remand to DIF for rulemaking.

In my view, the power to remand in these cases is inherent in the referees' and Board's authority to review the factual and legal correctness of DIF's orders awarding workers' compensation disability benefits. ORS 656.283(7) and ORS 656.295(5). Legislative history supports this view:

"If after all that [procedure to require DIF to adopt a temporary rule and apply it to a particular injury], the worker is still not satisfied that his impairment and his disability has been properly addressed, he then may appeal and go up to the Referee, Workers' Compensation Board, and into the courts just as they do now."

(Senator Shoemaker, Senate Floor Debate on SB 1197, Special Session, May 7, 1990. Emphasis added.)

In my view, it is a factual and legal fiction for the Board to agree with an order of DIF that there should be no award for a claimant's disability when a party has proved that a worker has disability caused by a compensable claim that has not been covered and compensated for by DIF's rules. It makes it appear to the parties and the public that, instead of neutral factfinders and judges of the evidence, we are merely rubber stamping the decisions of the agency whose orders we are supposed to be independently reviewing. It is impossible for the parties and the public to have confidence in that kind of appeal forum.

B. Extent of Permanent Disability

I disagree with the award for permanent disability made in the majority opinion. Serendipity intervened in this case to allow claimant an award by this Board despite DIF's failure to promulgate a rule at the time this case was pending there. While this claimant's appeal was pending at the Board, DIF, in response to another case, promulgated temporary rules pursuant to ORS 656.726(3)(f)(C) that covered chondromalacia of the knee. See temporary rules OAR 436-35-003 and OAR 436-35-230 in WCD Administrative Order 11-1992. Temporary rules are applicable regardless of the date of issuance of the determination order or notice of closure. Therefore, these temporary rules are applicable to this case. See OAR 436-35-003(2) and OAR 438-10-010(2). This temporary rule was recently made into a permanent rule without substantial amendment. See WCD Administrative Order 17-1992.²

The parties have not had an opportunity to brief the Board on the applicability of these rules. In my view, the parties should be allowed that opportunity. However, the issue is being decided despite the lack of the parties' argument, therefore, I proceed with the following analysis.

Only the attending physician may make findings of impairment. ORS 656.245(3)(b)(B). When an attending physician adopts the opinion of another medical provider, that opinion becomes the attending physician's opinion. Claimant's attending physician is Kenneth Freudenberg, M.D. The record reveals the following pertinent permanent impairment findings:

1. Ex. 6, September 11, 1990 Physical Capacities Evaluation by John Breuer, P.T. (adopted by Dr. Freudenberg in Ex. 7, September 26, 1990 chart note):

² The remainder of this discussion assumes that making a temporary rule (promulgated pursuant to ORS 656.726(3)(f)(C)) into a permanent rule does not make the rule inapplicable, although OAR 435-35-003(2) regarding applicability of rules does not expressly address this point.

"Mr. Gallino performed a full Functional Capacity Assessment to determine present work capacity and he was able to complete all the tests except squatting, bending and climbing. His lifting capabilities were limited by his subjective knee pain and this also resulted in poor body mechanics. He was unable to assume a squatting position and he also could not bend with his knees to pick up objects from the floor. Subjective pain levels were very high. The patient appeared to be discouraged with his progress. This evaluation places the patient in the 'light' category of the PDC Scale (see separate sheet). Currently Mr. Gallino is working as a Car Salesman."

Correlation between pain rating and observed behavior was good. The results indicated leg weakness and knee pain.

2. Ex. 7, Dr. Freudenberg's September 26, 1990 chart note:

He found claimant's condition medically stationary and he released him for work as recommended by John Breuer's physical capacity evaluation. He prescribed a patellar stabilizing brace.

3. Ex. 13, Dr. Freudenberg's report of March 11, 1991:

Claimant returned to work as a car salesman, "but continues to have a moderate amount of pain and functional limitations because of this. . . . I am aware that the Oregon Workers' Compensation Disability rating standards do not expressly mention the condition chondromalacia. I would say that the loss from his articular cartilage probably would be at least the same as total loss of his lateral meniscus. That should be in the 15% range."

This evidence shows that claimant has secondary loss of strength, patellar (knee) instability, and inability to repetitively use his knee to squat, bend and climb.

Now to apply these facts to the applicable rules. The applicable rules are those in effect on the date of issuance of the December 21, 1990 Notice of Closure and any relevant temporary rules (including applicable temporary rules that have been made into permanent rules. See footnote 2). OAR 436-35-003 (WCD Administrative Orders 11-1992 and 17-1992).

Permanent rule OAR 436-35-230(13) specifically addresses chondromalacia of the knee. Subsection (a) states:

"Except as provided in subsection (b) of this section: for chondromalacia, arthritis, or degenerative joint disease of the knee, the rating shall be determined pursuant to the chronic condition rule, if the criteria of OAR 436-35-010(6) are met."

The version of OAR 436-35-010(6) referred to above is the current version contained in WCD Administrative Order 6-1992. It states:

"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 as follows. 'Body part' as used in this rule means the foot/ankle, knee, leg, hand/wrist, elbow, and arm.

"(a) Scheduled chronic condition impairment is considered after all other scheduled impairment, if any, has been rated under these rules and converted, pursuant to OAR 436-35-120 and/or 436-35-240 to the appropriate body part proximal to the body.

"(b) Where scheduled chronic condition impairments exist for more than one body part in the same extremity, the worker shall receive only one 5% chronic condition impairment for the body part which results in the larger dollar amount of compensation to the worker. In no event is a worker entitled to more than one 5% scheduled chronic condition impairment in each injured extremity, regardless of how many body parts within that extremity are injured or have chronic conditions.

"(c) The value for the scheduled chronic condition impairment is combined (not added) with other scheduled impairment."

The above rules require that other types of impairment are first rated before we rate the chronic condition limiting repetitive use. Therefore, I proceed to the secondary strength loss factor.

1. Secondary Strength Loss

Permanent rule OAR 436-35-230(13)(b) states:

"A value of 5 percent of the leg shall be combined with other impairment values, including chronic condition as in (a) above, if there is a diagnosis of more extensive chondromalacia, arthritis, or degenerative joint disease and one or more of the following:

- (A) Grade IV chondromalacia
- (B) Secondary strength loss
- (C) Chronic effusion; or
- (D) Varus or valgus deformity less than that specified in subsection (4) of this rule."

I agree with the majority that claimant is entitled to 5 percent of the leg (knee) pursuant to OAR 436-35-230(13)(b)(B).

2. Patellar Instability

The patellar instability impairment is covered by former OAR 436-35-230(3) (Administrative Order 6-1988). That was the rule in effect at the time of the Notice of Closure and there is no more recent rule adopted pursuant to ORS 656.726(3)(f)(C) addressing this type of impairment. That rule measures impairment based on the knee joint opening from 1 millimeter to 4 millimeters for an award ranging from 5 percent to 30 percent. Although it is evident that Dr. Freudenberg found that claimant has knee instability, I am unable to determine an award for this factor because this evidence was not stated in terms of degree of knee joint opening as required by the rule. Further, there is insufficient evidence to determine if this disability is one that should be covered by some measurement other than degree of millimeters in the joint opening so that it could be compensated by further rule making by DIF.

3. Chronic Condition Limiting Repetitive Use

I disagree with the majority's conclusion that claimant is not entitled to an award for impairment limiting repetitive use of his knee due to his chronic chondromalacia. The majority relied upon former OAR 436-35-010(8)(a)(WCD Administrative Order 20-1990). However, it does not appear that rule is applicable to this case. Rather, I am guided by the current rule OAR 436-35-230(13)(a) and the rule it referred to, current OAR 436-35-010(6), cited above. There is no limitation in these current applicable rules of the kind cited in former OAR 436-35-010(8)(a). The current rules would allow 5 percent of the left leg for this impairment factor. However, this 5 percent must be combined, rather than added, to the prior 5 percent for secondary strength loss. OAR 436-35-230(13)(b).

4. Total Award

The total award should be 10 percent scheduled permanent, partial disability (PPD) of the left leg, or 15 degrees, based on the combined value of 5 percent for secondary strength loss and 5 percent for a chronic condition limiting repetitive use. Since claimant has already been awarded 5 percent PPD by the May 29, 1991 Order on Reconsideration which affirmed the SAIF Corporation's December 21, 1990 Notice of Closure, claimant should be awarded an additional award of 5 percent (7.5 degrees) to make up the total of 10 percent.

In the Matter of the Compensation of
LISA A. HYMAN, Claimant
WCB Case No. 91-03726
ORDER ON RECONSIDERATION
Welch, Bruun & Green, Claimant Attorneys
Jeff Gerner (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our November 6, 1992 Order on Review. In that order, we found that a "de facto" denial of medical services had occurred and we awarded claimant's attorney an assessed attorney fee under ORS 656.386(1) for prevailing finally over the "de facto" denial. On November 25, 1992, we withdrew our November 6, 1992 order for reconsideration. Having received claimant's response and SAIF's reply, we proceed with our reconsideration.

SAIF contends that we erred in relying on Deborah K. Atchley, 44 Van Natta 1435 (1992) for the proposition that a claim is "de facto" denied if it is not accepted or denied within 90 days. Citing Gloria J. Shelton, 44 Van Natta 2232 (1992), SAIF argues that even if an insurer fails to issue a notice of acceptance or denial within the 90 days time limit, an insurer cannot be held to have "de facto" denied a claim unless it manifests an intent to contest compensability of a worker's claim. SAIF also argues that it never questioned or doubted compensability of the medical services provided to claimant. Thus, SAIF argues that it did not manifest an intent to deny the claims for medical services, and that therefore, claimant's attorney is not entitled to an assessed fee under ORS 656.386(1) for his services in securing payment of the medical bills in question.

On reconsideration, we adhere to the conclusion, as did the court recently in Safeway Stores Inc. v. Smith, 117 Or App 224 (1992), that a claim for medical services is "de facto" denied if it is not accepted or denied within 90 days. Contrary to SAIF's contention, this is not a newly-established rule. See Barr v. EBI Companies, 88 Or App 132 (1987). In establishing this rule, the court recognized that when an insurer gives no response to a claim contrary to law, the insurer's unlawful conduct gives the claimant a legitimate reason to conclude that compensability of the medical services is being denied and a hearing should be requested. In other words, the violation of law is itself a manifestation of an intent to deny the claim; hence, the claim is deemed "de facto" denied.

Despite the finding of a "de facto" denial in a case, we agree that the insurer may seek to establish at the hearing that notwithstanding its failure to accept or deny the claim, it did not actually contest compensability of the medical services. Whether it did or did not contest compensability becomes a question of fact to be decided based on the evidence. Gloria J. Shelton, supra.

In this regard, we disagree with SAIF's contention that our conclusion is in conflict with the Shelton holding. In Shelton, we concluded that the claimant's attorney was not entitled to a carrier-paid fee under ORS 656.386(1) for obtaining increased temporary disability benefits under an accepted aggravation claim without a hearing. In reaching our conclusion, we reasoned that the statute authorized a carrier-paid fee only when the issue of causation is disputed and not merely the amount of compensation or extent of disability.

In support of her contention that causation was in dispute, the claimant in Shelton argued that the carrier had "de facto" denied her claim that she had been off work due to her compensable surgery (which had previously prompted the carrier's acceptance of her aggravation claim). We did not accept the claimant's characterization of the carrier's conduct as a "de facto" denial. Nevertheless, even assuming that the carrier's conduct constituted a "de facto" denial, we reasoned that the record did not support a conclusion that causation of a claim was disputed. Thus, we concluded that the claimant was not entitled to an attorney fee award under ORS 656.386(1).

Our holding in Atchley is consistent with this rationale. In Atchley, we awarded an attorney fee under ORS 656.386(1) because claimant's counsel was instrumental in obtaining compensation for claimant without a hearing; i.e., the payment of a prescription and mileage reimbursement claim. The carrier in Atchley conceded that its payment was more than 30 days late. Moreover, there was no contention that, prior to the carrier's payment, causation of the claim had been undisputed. In light of such circumstances, we reasoned that the claim was denied "de facto" once the statutory period for acceptance or denial had expired until the carrier paid the claim.

Here, the evidence shows that for a period of almost one year, SAIF received, but did not pay, some 35 billings for medical services provided to claimant, for a condition which claimant claimed as an aggravation of his accepted condition. Unlike the carrier in Shelton, SAIF had denied compensability of the aggravation claim. Consequently, claimant had to request a hearing to challenge that denial and to obtain payment for the medical services. Apart from the erroneous assertion by SAIF's attorney that the billings had been paid, at hearing, SAIF offered no explanation, let alone evidence, to establish why it did not pay the medical billings.

Under the circumstances, we find that the evidence preponderates in favor of the conclusion that the billings went unpaid for almost a year while the aggravation claim was in a denied status, because SAIF failed to distinguish between claimant's right under ORS 656.245 to medical services for the accepted condition and the aggravation claim which SAIF had lawfully denied. That was essentially the situation the court face in Evans v. SAIF, 62 Or App 182 (1983), wherein the court set aside SAIF's "de facto" denial of medical services and awarded claimant's attorney an assessed fee under ORS 656.386(1) for his services in prevailing on the issue.

Accordingly, on reconsideration, we adhere to the conclusion that claimant's attorney is entitled to an assessed attorney fee under ORS 656.386(1) for prevailing finally over SAIF's "de facto" denial. Deborah K. Atchley, supra; Gloria J. Shelton, supra.

Finally, claimant seeks an increase in the \$1,500 attorney fee granted by our prior order. Specifically, she seeks \$1,500 for services on Board review and \$300 for services on reconsideration. We decline claimant's request.

The issue before us on review was claimant's entitlement to an attorney fee for services at the hearing level for prevailing against SAIF's "de facto" denial. Since attorney fees under ORS 656.386(1) do not constitute compensation, claimant is not entitled to an attorney fee for services on review for finally prevailing on the issue. See Amador Mendez, 44 Van Natta 736 (1992). Likewise, to the extent that claimant is seeking an attorney fee for defending our previous attorney fee award, she is not entitled to a fee for such services. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

Accordingly, our November 6, 1992 order is withdrawn. On reconsideration, as modified and supplemented herein, we republish our November 6, 1992 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

December 29, 1992

Cite as 44 Van Natta 2517 (1992)

In the Matter of the Compensation of
LORI KEEFAUVER, Claimant
WCB Case No. 91-16780
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Phillip Nyburg, Defense Attorney

Reviewed by Board Members Gunn and Westerbund.

Claimant requests review of those portions of Referee Mongrain's order that affirmed an Order on Reconsideration that awarded 30 percent (96 degrees) unscheduled permanent disability and awarded no scheduled permanent disability. In her brief, claimant contends that the Referee erred in declining to admit Exhibit 11, a post-Reconsideration Order medical report from her attending physician. On review, the issues are evidence and extent of scheduled and unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINIONEvidentiary Matter

On review, claimant contends that the Referee erred in excluding proposed Exhibit 11, a post-Reconsideration Order medical report from claimant's treating physician. We disagree.

The medical report at issue is dated February 13, 1992, which is approximately three months after the date of the November 20, 1991 Order on Reconsideration. We have previously held that medical evidence generated after the date of the Order on Reconsideration will not be considered, in spite of the fact that such post-Reconsideration Order evidence comes from the attending physician. Nancy A. Worth, 44 Van Natta 2345 (1992); Gary C. Fischer, 44 Van Natta 1517 on recon 44 Van Natta 1655 (1992).

Here, although proposed Exhibit 11 is from claimant's attending physician, it was generated well after issuance of the November 20, 1991 Order on Reconsideration. Thus, it is not admissible. Nancy A. Worth, *supra*.

Accordingly, the Referee correctly declined to admit the disputed exhibit.

Extent of Scheduled Disability

We adopt the Referee's conclusions and reasoning concerning the extent of scheduled permanent disability.

Extent of Unscheduled Disability

We adopt the conclusions and reasoning of the Referee concerning the extent of claimant's unscheduled permanent disability, with the following supplementation.

The Referee applied the standards in effect on the date of the September 25, 1991 Determination Order. (WCD Admin. Order 2-1991). Claimant agrees with the values assigned by the Referee under the standards for age (0), education (4), and impairment (15). The only dispute raised by the parties on review is the correct value for the adaptability factor.

Claimant argues that her attending physician released her to sedentary work with restrictions and that, consequently, her adaptability factor should be rated at 6 pursuant to former OAR 436-35-310(3). We disagree.

Former OAR 436-35-270(3)(e) provides that, in order to be sedentary with restrictions, the worker must be permanently restricted from "(A) Lifting any amount less than 10 pounds; (B) Performing two or more of the following activities: reaching handling, fingering and/or feeling; or (C) One or more of the following activities: talking, hearing and seeing." The record does not support a finding that claimant is so severely disabled that she is permanently restricted to lifting less than 10 pounds or is restricted from performing any one of the activities listed. Therefore, under the applicable standards, claimant's residual physical capacity is not sedentary with restrictions.

Relying on claimant's testimony that the job she performed at closure required lifting up to 40 pounds as well as a great deal of bending and stooping, the Referee determined that claimant's functional capacity was light and that, consequently, claimant's adaptability factor should be 3. On review, claimant contends that the modified work she performed at the time of closure was not relevant to the determination of her residual functional capacity. Instead, claimant contends that, under former OAR 436-35-270(3)(d), reliance upon the medical evidence concerning residual functional capacity is favored over evidence concerning the strength required by the work claimant was performing at closure. We disagree.

Former OAR 436-35-270(3)(d) provides that maximum residual capacity is the greatest capacity evidenced by the attending physician's release; or by a preponderance of medical opinion which

includes a physical capacities evaluation or the strength of any job at which a worker has returned to work at the time of determination.¹

Based on its plain language, this rule does not favor one manner of determining maximum physical capacity over another, but requires us to determine which of the three things contained in the rule evidences the greatest residual capacity. Here, claimant's attending physician released her to sedentary work. However, the work claimant testified she returned to required her to lift up to 40 pounds and to bend and stoop frequently. Moreover, there is no persuasive evidence that claimant's injury prevented her from performing that job. Thus, we conclude that for purposes of former OAR 436-35-270(3)(d), claimant's greatest capacity was evidenced by the work to which she returned. Accordingly, we agree with the Referee that an adaptability factor of 3 is appropriate.

ORDER

The Referee's order dated April 21, 1992 is affirmed.

¹ Former OAR 436-35-270(3)(d) provides:

"Residual Functional Capacity' (RFC) means an individual's remaining ability to perform work-related activities despite medically determinable impairment resulting from the accepted compensable condition. A residual functional capacity evaluation includes, but is not limited to, capability for lifting, carrying, pushing/pulling, standing, walking, sitting, climbing, balancing, stooping, kneeling, crouching, crawling, and reaching. Maximum residual capacity is the greatest capacity evidenced by:

"(A) The attending physician's release; or

"(B) By a preponderance of medical opinion which includes but is not limited to a second level PCE or WCE. Where a worker fails to cooperate or use maximal effort in the PCE or WCE, the worker's RFC shall be determined based upon the preponderance of medical opinion as to the worker's likely work capacities had the worker cooperated and used maximal effort; or

"(C) The strength of any job at which a worker has 'returned to work' at the time of determination."

December 29, 1992

Cite as 44 Van Natta 2519 (1992)

In the Matter of the Compensation of
GLORIA T. OLSON, Claimant
WCB Case No. 91-16193
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Meyers & Radler, Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Quillinan's order that: (1) upheld the self-insured employer's denial of claimant's aggravation claim for a right shoulder condition; and (2) held that the Hearings Division lacked jurisdiction to address claimant's medical services claim for right rotator cuff surgery. On review, the issues are aggravation and jurisdiction. We affirm in part and modify in part.

FINDINGS OF FACT

In January 1988, claimant injured her right shoulder while lifting boxes of produce at the employer's store. She sought treatment from Dr. Gurney, who diagnosed tendinitis and prescribed physical therapy. In May 1988, she was referred to Dr. Smith, who found no evidence of a rotator cuff tear but noted degenerative changes of the right acromioclavicular joint. Claimant did not respond to conservative treatment and, in November 1988, underwent surgical excision of the distal clavical, with removal of osteophytes from the acromion and the division of the acromioclavicular joint. The employer accepted a claim for a right shoulder strain, and claimant was ultimately awarded benefits for 31 percent unscheduled permanent partial disability pursuant to a June 11, 1990 Stipulation and Order.

Claimant returned to regular work, but continued to experience shoulder discomfort. In October 1990, she sought additional treatment from Dr. Jones, who ordered an MRI scan that revealed no evidence of a rotator cuff tear. Her symptoms worsened and, in June 1991, Jones noted increased tenderness over the rotator cuff musculature with crepitation in the area of her lateral clavical resection. He ordered an arthrogram, which at that time revealed a small rotator cuff tear. After a conservative treatment failed to provide significant relief, Jones requested authorization to perform a subacromial decompression and rotator cuff repair.

In September 1991, claimant was examined by Drs. Peterson and Fuller at the employer's request. Based on claimant's history, they opined that the rotator cuff tear was caused by claimant's preexisting degenerative condition and was not related in major part to her 1987 compensable injury. They also opined that the requested surgery was not reasonable and necessary for claimant's current condition.

On November 1, 1991, the employer denied claimant's aggravation claim, asserting that her current condition was not compensably related to her industrial injury. It also denied claimant's medical services claim for right rotator cuff surgery as not reasonable and necessary medical treatment. Claimant timely requested a hearing.

CONCLUSIONS OF LAW AND OPINION

Aggravation

Claimant has filed a claim alleging an aggravation under ORS 656.273(1), which 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."

There is no real dispute that claimant's right shoulder condition has worsened. The issue is whether the relationship between that worsening and the original injury is sufficient to establish compensability. The Referee concluded that it was not, because claimant failed to prove that the injury was the major contributing cause of the worsened condition.

On review, claimant contends that the Referee erred in applying the major contributing cause standard in order to establish compensability. She argues that the limiting feature of ORS 656.005(7)(a)(B) does not apply to aggravation claims and that she is required only to prove that her injury is a material contributing cause of the worsening. We disagree.

The general rule is that a compensable worsening is established by proof that the original injury is a material contributing cause of the worsened condition. See Robert E. Leatherman, 43 Van Natta 1677 (1991). In this case, however, the medical evidence establishes that claimant's worsening is the result of a combination of her compensable injury and her preexisting degenerative shoulder condition. Because the injury combined with a preexisting condition to cause a need for treatment and disability, the appropriate statute for determining the compensability of the worsened condition is ORS 656.005(7)(a)(B). See Bertha M. Gray, 44 Van Natta 810 (1992); Lareta C. Creasey, 43 Van Natta 1735 (1991). Thus, in order to establish an aggravation claim, claimant must prove that the original injury remains the major, rather than a material, contributing cause of the worsened condition.¹

Claimant next asserts that her degenerative shoulder condition cannot constitute a preexisting disease under ORS 656.005(7)(a)(B), because the employer had previously accepted that condition. She relies on the fact that the employer approved payment for her November 1988 surgery, which claimant maintains was performed solely to alleviate symptoms of her degenerative arthritis, and did not object to a Determination Order award of benefits for residuals of that surgery.

¹ Although a signatory to this order, Board Member Gunn directs the parties' attention to his dissenting opinion in Thomas L. Fitzpatrick, 44 Van Natta 877 (1992).

We addressed a similar argument in Richard R. Zippi, 44 Van Natta 1278 (1992), where we held that, as a matter of law, a previously accepted condition could not constitute a "preexisting disease or condition" as that term is used in ORS 656.005(7)(a)(B). Zippi does not apply here, however, because there is no evidence that the employer accepted claimant's degenerative shoulder condition and notified her of that acceptance. Georgia-Pacific v. Piwowar, 305 Or 494 (1988). Rather, we conclude that the employer only accepted claimant's claim for a right shoulder strain that she sustained while lifting boxes of produce. The fact that the employer may also have provided benefits for her underlying condition is inapposite, because "[m]erely paying or providing compensation shall not be considered acceptance of a claim or admission of liability." ORS 656.262(9).

Claimant also contends that, in upholding the employer's denial, the Referee erred in relying on the opinion of Drs. Peterson and Fuller. Claimant argues that the Referee should have given more weight to the opinion of Dr. Bert, an associate of Dr. Jones who took over claimant's care in October 1991.

When there is a dispute between medical experts, we rely on those opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). After our review, we find that only the opinion of Drs. Peterson and Fuller meets both criteria and, accordingly, give it the most weight. We give less weight to the opinion of Dr. Bert, because it is conclusory and not thoroughly explained. His opinion states only: "I feel that the 1988 injury and subsequent treatment is the major factor." (Ex. 40-3). As noted by the Referee, he failed to explain how the original injury that occurred some two years earlier could be the major contributing cause of a new, discretely identifiable condition in the absence of any objective or symptomatic findings of this condition prior to April 1991.

In contrast, the opinion of Drs. Peterson and Fuller was well-reasoned and persuasive. Although they agreed that the original injury may have hastened claimant's degenerative condition, they opined that the injury is not the major cause of the current rotator cuff tear. Instead, they believe that the rotator cuff tear was a spontaneous event caused by the ongoing degenerative process, which accounts for claimant's persistent right shoulder symptoms.

In short, we conclude that claimant has failed to establish that the original injury remains the major contributing cause of her worsened condition. Accordingly, we agree with the Referee that claimant has failed to establish a compensable aggravation claim. The employer's denial is upheld.

Jurisdiction

Claimant also seeks review of that part of the Referee's order that dismissed her hearing request on the employer's denial of medical services. We agree with claimant to the extent that the dispute concerned the causal relationship between the proposed surgery and original injury. See Michael A. Jaquay, 44 Van Natta 173 (1992). Nonetheless, assuming that such a dispute was raised, we have concluded that claimant's current condition is the result of a combination of her compensable injury and her preexisting degenerative shoulder condition. Because the injury is not the major contributing cause of the current condition, it follows that claimant is not entitled to medical services for that condition. ORS 656.005(7)(a)(B); Elizabeth A. Bonar-Hanson, 43 Van Natta 2578 (1991).

ORDER

The Referee's order dated February 13, 1992 is affirmed in part and modified in part. The employer's medical services denial is upheld to the extent that it denied that the proposed surgery is causally related to the compensable injury. The remainder of the order is affirmed.

In the Matter of the Complying Status of
SPENCER HOUSE MOVING COMPANY, Noncomplying Employer

WCB Case No. 90-21911
ORDER OF DISMISSAL
Brothers, et al., Attorneys
Stephen P. Forte, Attorney
Bonnie Laux (Saif), Defense Attorney

Reviewed by Board Members en banc.

Claimant requests review of Referee Quillinan's order that: (1) concluded that claimant was not a subject worker at the time of injury; and (2) set aside the Director's order finding Carl Spencer to be a noncomplying employer. On review, the issue is subjectivity. We dismiss for lack of jurisdiction.

FINDINGS OF FACT

On August 28, 1990, claimant filed a claim for compensation, alleging that he had received a severe electrical burn while working for Carl Spencer, dba Spencer House Moving. On October 11, 1990, the Workers' Compensation Department issued an order declaring Spencer to be a noncomplying employer and referred the claim to SAIF for processing. SAIF accepted the claim and began paying benefits. Spencer disputed the order of noncompliance and filed a request for a hearing (WCB Case No. 90-21911). In addition, claimant requested a hearing concerning SAIF's processing of his claim and its alleged failure to pay certain medical bills (WCB Case No. 90-22024). The requests were consolidated for hearing.

At the commencement of the hearing, claimant withdrew his hearing request and indicated that compensability was not at issue. The hearing proceeded solely on the question of whether Spencer was a noncomplying employer. The Referee concluded that claimant was not a subject worker and set aside the order of noncompliance. The Referee's order provided appeal rights allowing either party to file a petition with the Court of Appeals. Instead, claimant requested Board review.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

A threshold issue not raised by either party is whether we have jurisdiction for review. Specifically, we must determine whether the Referee's order is a final order of the Director appealable only to the Court of Appeals, as provided in the parties' notice of appeal rights. We conclude that it is and dismiss for lack of jurisdiction.

The issue of whether a person is a noncomplying employer generally arises through the filing of a claim for compensation by an injured worker. In such a case, where the Workers' Compensation Department has concluded that the employer is noncomplying, the claim is referred to the SAIF Corporation, which is required to process the claim under ORS 656.054(1). If SAIF accepts the claim, the employer may contest compensability by filing a request for hearing with the Board pursuant to ORS 656.283(1). Clark v. Linn, 98 Or App 393 (1989).

As a separate matter, the employer may also contest the Department's order of noncompliance by requesting a hearing pursuant to ORS 656.740. That request, however, is filed with the Department of Insurance and Finance rather than the Board, and the order of the referee is deemed to be a final order of the Director. ORS 656.740(1) and (3). Furthermore, jurisdiction for review of the Referee's order is conferred upon the Court of Appeals pursuant to ORS 656.740(4), except that:

"(c) When an order declaring a person to be a noncomplying employer is contested at the same hearing as a matter concerning a claim pursuant to ORS 656.283 and 656.704, the review thereof shall be as provided for a matter concerning a claim."

The statutory framework does not require that these two proceedings be consolidated for hearing if both are invoked. Nonetheless, such consolidation often occurs and, in those cases, we have concluded that we have jurisdiction to conduct review. For example, in Michael D. Owings, 42 Van

Natta 626 (1990), the employer requested a hearing on both the Department's order of noncompliance and SAIF's acceptance of the claimant's injury claim. Because an order of noncompliance was contested at the same hearing as a matter concerning a claim, we concluded that we had jurisdiction to entertain the employer's appeal of the referee's order.

In comparison, we have held that we lack jurisdiction to review a referee's order addressing the issue of noncompliance in cases where the proceedings were not consolidated or where the employer contested only the Director's order. For example, in Daniel R. Jordison, 42 Van Natta 1946 (1990), aff'd mem 107 Or App 784 (1991), the employer requested a hearing only on a proposed order of noncompliance. Because no other issue was contested at the hearing, we concluded that we lacked jurisdiction to review the referee's order. See also Derwin W. Wilson, 43 Van Natta 360 (1991); Larry J. Powell, 42 Van Natta 1594 (1990); Denise K. Rodriguez, 40 Van Natta 1788 (1988); Stanley Wilson, 40 Van Natta 387 (1988). The Court of Appeals recently agreed with that determination in Ferland v. McMurtry Video Productions, 116 Or App 405 (1992). In Ferland, an employer requested a hearing on an order of noncompliance. A referee upheld the order, concluding that the injured claimant was a subject worker of the noncomplying employer. When both parties requested Board review, we dismissed for lack of jurisdiction, holding that review authority rested with the Court of Appeals under ORS 183.482. The court affirmed, explaining:

"Unless an order declaring a person to be a noncomplying employer is contested at the same hearing as a matter concerning a claim, it is an order in a contested case, subject to judicial review under ORS 183.482. ORS 656.470(4)(c). The hearing before the referee on DIF's proposed order concerned only the status of the employer. The hearing did not concern claimant's claim, which was being processed by SAIF under ORS 656.054(1). The Board properly dismissed claimant's appeal."

The court's decision in Ferland is consistent with its prior acceptance of direct appellate review in Castle Homes, Inc. v. Whaite, 95 Or App 269 (1989). In Whaite, a referee affirmed an order of noncompliance, finding that the claimant was a subject worker. The employer directly petitioned the court for judicial review of the referee's order. Before proceeding to determine whether the claimant was, in fact, a subject worker, the court expressly stated that its review was "pursuant to ORS 183.480 and ORS 183.482." 95 Or App at 271.

Considering this matter in light of those cases, we conclude that we lack jurisdiction to review the Referee's order before us. Although claimant requested a hearing on SAIF's alleged failure to pay medical bills, he withdrew his request at the commencement of hearing and the hearing proceeded only on the employer's status. As in Ferland, Whaite, and Jordison, the only issue contested at the present hearing was whether the employer was noncomplying such that the Director could assess a civil penalty under ORS 656.735 or recover claims costs under ORS 656.054(3). Unlike Owings, supra, the present employer did not contest SAIF's acceptance of the claim, but rather limited its objections to the Department's findings that claimant was a subject worker and the employer was noncomplying. Because no matter concerning a claim was contested at the same hearing as the order of noncompliance, we lack jurisdiction under to ORS 656.740(4).

The dissent would hold that the Board has jurisdiction to review a referee's subjectivity determination, even if that determination is made solely for the purpose of deciding whether an employer is noncomplying. We consider such a conclusion to contravene the plain language of ORS 656.740(4)(c), which requires that another issue, i.e., one involving a "matter concerning a claim," be contested at the same hearing in order for the Board to be vested with jurisdiction.

The dissent argues that the Referee's subjectivity determination constitutes a "matter concerning a claim." We disagree. ORS 656.704(3) defines "matters concerning a claim":

"[M]atters concerning a claim under ORS 656.001 to 656.794 are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." (Emphasis supplied.)

"Directly" is defined as "without medium, agent, or go between; as soon as possible." Funk & Wagnalls Standard Desk Dictionary, 180 (1980). In this case, the Referee's conclusion that claimant is

not a subject worker may affect his right to receive compensation at a later date. However, neither SAIF nor the employer had challenged the compensability of his claim. Accordingly, claimant's right to receive compensation was not directly in issue before the Referee. As stated above, the hearing concerned only the status of the employer.¹

The dissent also attempts to distinguish this case from Whaite and Ferland. It first argues that the court's acceptance of direct appellate review in Whaite is inapposite, because "jurisdiction occurred without question." (Emphasis in original.) We reject that argument for three reasons. First, as the dissent itself recognizes, jurisdiction cannot be waived and a decision-making body should address the issue sua sponte if not raised by the parties. Southwest Forest Industries v. Anders, 299 Or 205 (1985). Second, pursuant to rules of appellate procedure, parties are required to designate the authority under which the court will be conducting its review. ORAP 5.40(3); 5.55. Third, as noted above, the Whaite court expressly addressed its authority for reviewing the petition from the Referee's order. In light of those factors, we believe that, when the court accepted appellate review, it is reasonable to assume that it believed it was correct and acted with knowledge in doing so. Because this case presents an identical issue, we are compelled to hold that appellate jurisdiction does not rest with this forum. To hold otherwise would require a conclusion that the Whaite court did not mean what it most clearly and unambiguously said.

The dissent next argues that Ferland should be ignored, because the "opinion appears to be directly contrary to the [c]ourt's earlier opinion in Lasiter [v. SAIF], 109 Or App 464 (1991)." That is incorrect. Lasiter involved the question whether a prior compliance proceeding, in which the claimant did not participate, precluded the claimant from contesting SAIF's denial of the claim on the basis that the claimed condition was not sufficiently work-related. The court concluded that, technically, claimant was not precluded from litigating the compensability of the claim, but added that the problem was that, because of the prior determination, there was not a subject employer against which the claimant could claim. While Lasiter demonstrates the effect a compliance determination may have on the future processing of a claim, it does not speak to the issue presented in Ferland, which was what review body was authorized to consider an appeal resulting from a hearing before a referee on an order of noncompliance concerning only the status of the employer. Thus, Ferland directly controls the issue presently before us.

In any event, the court's reasoning in Lasiter is consistent with its Ferland holding regarding appellate review authority under ORS 656.740. Specifically, the Lasiter court noted that the claimant could have participated in the noncompliance proceeding or he could have consolidated that proceeding with "the compensability proceeding, ORS 656.740." Lasiter v. SAIF, supra, 109 Or App at page 467. Such a comment demonstrates the court's appreciation for the difference between a subject worker dispute arising from a noncompliance proceeding (i.e., the status of the employer) and a compensability dispute arising from SAIF's processing of the claim under ORS 656.054. The Lasiter court's citation to ORS 656.740 in conjunction with its reference to consolidation of the noncompliance proceeding with "the compensability proceeding" is also supportive of the Ferland court's conclusion that, pursuant to ORS 656.740(4)(c), appellate review authority rests with the court unless a matter concerning a claim is contested at a hearing regarding a noncomplying employer order.

¹ The flaw in the dissent's analysis is demonstrated by the situation where an employer has challenged an order of noncompliance, while the claim for compensation has been denied and is unappealed. The dissent contends that Board appellate jurisdiction is secured whenever a Referee's subjectivity determination is rendered in a noncomplying employer order proceeding regarding a "filed and pending claim." Thus, the dissent would presumably agree that the hearing on an order of noncompliance in our example would not involve a "matter concerning a claim," and, therefore, appellate review authority would rest with the court. However, the necessary components of a subject worker determination arising from an order of noncompliance are the same regardless of whether SAIF has accepted or denied the claim on the employer's behalf. Moreover, there is no reason why appellate review of such a dispute would not be the same. Yet, by premising its appellate review determination on a "filed and pending claim," the dissent would presumably argue that review of the same subject worker determination will vary depending on whether SAIF's acceptance or denial of the claim remains "pending," irrespective of whether that processing decision has been raised as an issue at the same hearing as the noncomplying employer order. We cannot accept a proposition that the statutory scheme envisions separate review systems entirely dependent on events which occur outside the record and are not at issue.

Moreover, even if we assume that the Ferland and Lasiter decisions are in conflict, the dissent overlooks a well established principle of stare decisis: Where former decisions are apparently in conflict, the court is bound by the latter utterance. Libby v. Southern Pac. Co., 109 Or 449, 459 (1923). Accordingly, Ferland would control.

Finally, the dissent's reliance on Salter v. SAIF, 108 Or App 717 (1991), is misplaced. In that case, the employer orally denied compensability of the claim at the hearing and, in fact, had issued a written denial of the claim in advance of the hearing. Thus, in addition to the employer's appeal of the order of noncompliance, compensability of the claim was expressly raised as an issue at hearing. As in Michael D. Owings, supra, appellate review authority clearly rests with the Board, because a matter concerning a claim was contested in conjunction with a noncomplying employer order. Because the hearing at issue here pertained solely to the status of the employer, appellate jurisdiction lies with the Court of Appeals.

In reaching this decision, we recognize that a subject worker determination in a compliance proceeding may have a potentially significant impact on the future processing of a claim, as demonstrated by the court's holding in Lasiter. Nonetheless, our appellate authority is triggered not by the possible effect of such a determination, but rather on the simple prerequisite that the order of noncompliance is contested at the same hearing as a matter concerning a claim. Because the hearing before the Referee concerned only the order of noncompliance, we lack jurisdiction for review. As indicated by the Referee's order, jurisdiction over this matter is vested in the Court of Appeals. Claimant's request for review is dismissed.

IT IS SO ORDERED.

Board Members Westerband and Gunn specially concurring:

The dissent argues that, where a determination of an employer's alleged noncompliance turns on whether the claimant is a subject worker, the determination necessarily involves a matter concerning a claim, and therefore, review of the Referee's order is by the Board. We believe that argument has some appeal.

From a common sense point of view, it may be somewhat difficult to understand why a "worker's right to receive compensation" is not "directly in issue" where the question of employer noncompliance wholly depends on whether the claimant was a subject worker at the time of injury. Although the purpose of the proceeding is to determine if the employer is noncomplying, the employer's defense is that the claimant was not a subject worker, and had no right to receive compensation for the injury. A final determination made of nonsubject worker status is binding on the claimant. That determination alone, if not overturned on appeal, will defeat the claimant's claim for compensation. Lasiter v. SAIF, 109 Or App 464 (1991). Therefore, we appreciate the policy reason for the argument that where the employer asserts in defense against a charge of noncompliance that a claimant was not a subject worker at the time of injury, the question of employer noncompliance is necessarily joined with a matter concerning a claim because a worker's right to receive compensation is "directly in issue."

On the other hand, express findings and conclusions after a full administrative agency hearing involving an essential and disputed issue can have the same preclusive effect under res judicata principles on a civil action in state or federal court. See Heller v. Ebb Auto Co., 308 Or 1 (1989) (the question was whether a decision of the Employment Appeals Board had preclusive effect on a federal suit under Title VII of the Civil Rights Act of 1964). Despite such effects, it clearly cannot be said that the case before the administrative agency "directly" involves the related, but entirely separate court litigation.

Were the issue one of first impression for the Board, we might have to decide whether or not to join in the dissent. However, the question presented is not one of first impression. The Board has consistently dismissed, for lack of jurisdiction, appeals concerning noncompliance orders where the issue of noncompliance turned on the claimant's subject worker status. See Harry J. Powell, 42 Van Natta 1594 (1990); Denise K. Rodriguez, 40 Van Natta 1788 (1988); Stanley Wilson, 40 Van Natta 387 (1988). When appealed, our decisions on this point have consistently been affirmed. See Ferland v.

McMurtry Video Productions, 116 Or App 405 (1992); Daniel R. Jordison, 42 Van Natta 1946 (1990), aff'd mem, 107 Or App 784 (1991); see also Castle Homes, Inc. v Whaite, 95 Or App 269 (1989), wherein, the court exercised, without question, jurisdiction of a direct appeal from a referee's order even though the noncompliance issue turned solely on the claimant's subject worker status.

In any event, under the circumstances, we believe that the argument made by the dissent must be made to the Court of Appeals. The present case, if appealed to the court, will present the court with an opportunity to consider the dissent's analysis.

For these reasons, we believe that dismissal of the request for review is appropriate.

Board Member Kinsley specially concurring.

I agree with the majority's conclusion that this case must be dismissed based on Ferland v. McMurtry Video Productions, 116 Or App 405 (1992). However, with all due respect, I believe that the holding in Ferland that finds that the Board did not have jurisdiction of the party's appeal is incorrect. When, as here, the Department of Insurance and Finance (DIF) or a referee determines that there is no employment relationship between a claimant and an alleged employer, that claimant will not receive workers' compensation benefits. The majority states that this determination only "may" affect a claimant's right to receive compensation. However, the majority opinion gives no example of how a claimant could receive compensation after DIF or a referee concludes that no employment relationship existed at the time the claim arose. To be sure, I can think of no reason why the SAIF Corporation would pay benefits under ORS 656.054(1) if DIF or a referee has found no employment relationship.

The Workers' Compensation Board has been given jurisdiction over "matters concerning a claim." ORS 656.704(3). Those matters are defined as "matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." Id. There are various assertions and defenses that may arise in a proceeding before DIF about whether or not a person or business is a noncomplying employer. However, when, as here, an alleged noncomplying employer asserts in his defense that there was no employment relationship with the claimant, that case necessarily involves a matter concerning a claim because, if successful, the claimant will not receive compensation. Where, as here, an order from DIF involves a matter concerning a claim, the parties should take the usual appeal route from the referee to the Board, then from the Board to the Court of Appeals. ORS 656.740(4)(c), 656.289(3), 656.295 and 656.298. That is the route that the parties took in this case and I believe that is what the legislature intended. We frequently decide cases (other than those that arise at DIF) in which the issue is whether an employment relationship exists between a claimant and an alleged employer, and there is never any question that the issue is a matter concerning a claim. By writing ORS 656.740(4)(c), the legislature recognized that this issue might be raised in the DIF forum and they wanted the parties to have the same rights of appeal as when the same issue was raised in a hearing under ORS 656.283. That makes sense.

Finally, if one still does not believe that this issue about an employment relationship affects this claimant's "right to receive compensation," just ask the parties. They will tell you that, as a direct result of the Referee's determination that no employment relationship existed, the alleged employer and SAIF are not paying benefits and the claimant is not receiving benefits. It's that simple.

Board Member Hooton dissenting.

I agree that it is necessary to consider whether the Board has jurisdiction to review the Referee's order in this claim. Because the issue of jurisdiction is not raised by either party it is appropriate and necessary for the Board to consider the question sua sponte. I disagree, however, with the characterization of the question to be determined and with its ultimate resolution.

The majority opinion states that "we must determine whether the Referee's order is a final order of the Director appealable only to the Court of Appeals, as provided in the parties' notice of appeal rights." That is incorrect. What we must determine is whether the Referee's order resolved a matter concerning a claim. The relevant statute is ORS 656.740 (4), which provides, in part:

"Notwithstanding ORS 183.315(1), the issuance of orders declaring a person to be a noncomplying employer or assessing civil penalties pursuant to this chapter, the conduct of hearings and the judicial review thereof shall be as provided in ORS 183.310 to 183.550, except that:

* * *

"(c) When an order declaring a person to be a noncomplying employer is contested at the same hearing as a matter concerning a claim pursuant to ORS 656.283 and 656.704, the review thereof shall be as provided for a matter concerning a claim."

ORS 656.704(3) defines "matters concerning a claim":

"[M]atters concerning a claim under this chapter are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue."

The courts have spent considerable effort in determining the scope of ORS 656.704(3). The phrase "matters concerning a claim" has been construed to include any circumstance involving the direct payment of benefits to, or the recovery of overpayments from, an injured worker. See Hayden v. Workers' Compensation Dept., 77 Or App 328 (1986); SAIF v. Harris, 66 Or App 165 (1983); Petshow v. Portland Bottling Co., 62 Or App 614 (1983). Furthermore, the courts have construed "matters concerning a claim" to include those matters that are derivative of a worker's rights or entitlements. For example, the courts have determined that such derivative questions as a third party election, EBI Companies v. Cooper, 100 Or App 246 (1990), third party distribution, Schlecht v. SAIF, 60 Or App 449 (1982), the determination of a paying agent, SAIF v. Wright, 312 Or 132 (1991), attorney fees in questions involving the denial of vocational services, SAIF v. Severson, 109 Or App 136 (1991), and the enforcement of a disputed claims settlement, even though those proceeds are not compensation, Howard v. Liberty Northwest Ins., 94 Or App 283 (1988), are all "matters concerning a claim" under ORS 656.704(4).

From a review of these cases, it is evident that the courts have found any matter which influences or determines the payment of benefits or the amount of those benefits, whether that influence is immediate or remote, is a matter concerning a claim.

Despite the courts liberal construction of the phrase "matters concerning a claim", we held in Derwin W. Wilson, 43 Van Natta 360 (1991), that we lacked jurisdiction to review a referee's determination of subjectivity made for purposes of deciding a noncompliance issue. In that case, an employer requested a hearing from an order of noncompliance. In addition, the claimant requested a hearing seeking penalties and attorney fees for an alleged discovery violation. At hearing, however, the claimant withdrew his request regarding the claim processing issue, and the hearing proceeded only on the issue of whether the claimant was a subject worker. Although the referee subsequently determined that the claimant was not a subject worker under the Workers' Compensation Law, we concluded that we lacked jurisdiction to review the referee's order. We explained:

"Claimant withdrew his request for hearing at the commencement of the hearing. Thus, it cannot be said that a matter concerning a claim was contested at the hearing. Rather, the only issue actually contested at hearing was subjectivity for purposes of deciding the noncompliance issue. Because no matter concerning a claim was contested at the same hearing as the compliance issue, the Board does not have jurisdiction over claimant's appeal of the Referee's order. 43 Van Natta 360, 361 (Emphasis omitted.)

I disagree with the reasoning stated above. It reveals that the Board simply assumed that a matter arising from a proceeding over which the Director had jurisdiction by statute could not be a matter concerning a claim. See also Daniel R. Iordison, 42 Van Natta 1946 (1990), aff'd mem 107 Or App 784 (1991); Larry J. Powell, 42 Van Natta 1594 (1990); Denise K. Rodriguez, 40 Van Natta 1788 (1988); Stanley Wilson, 40 Van Natta 387 (1988). The fact of the matter is that there are any number of issues that are undoubtedly matters concerning a claim over which both the Director and the Board have some jurisdiction as a matter of legislative directive. The determination of eligibility for vocational

services, some medical services questions and the rating of extent of disability are all issues on which the Director and the Board share authority. Each of these issues involve matters concerning a claim.

After further consideration of Derwin W. Wilson, supra, I find that decision in error and conclude that we have jurisdiction to review such orders. The majority, in its argument in support of the cases listed above, focuses upon the situs of the proceeding giving rise to the request for review. The statute, however, does not direct the Board to consider that question. Rather, the parties are entitled to de novo review by the Board whenever an issue involving a matter concerning a claim is determined in a proceeding involving a Director's proposed order of noncompliance. It is not the request for hearing that is the focus of ORS 656.740(4)(c) but the issues resolved. It is not the situs, but the substance which determines the Board's review authority.

The issue of whether an employer is a noncomplying employer often arises through the filing of a claim for compensation by an injured worker. In those cases the employer may challenge the order of noncompliance by asserting that he is not an employer of any subject workers. The employer's defense, if successful, would deprive the injured worker of the right to receive compensation for his injury, because the Workers' Compensation Law provides benefits only to subject workers of subject employers. ORS 656.017. Therefore, contrary to our prior holding, the Referee's subjectivity determination is a "matter concerning a claim" under ORS 656.704, and subject to our review. ORS 656.740(4)(c).

Accordingly, I conclude that, regardless of whether any other issues are contested at hearing, the Board has jurisdiction to review a referee's subjectivity determination made for purposes of determining compliance where that determination pertains to a filed and pending claim. Such a decision directly concerns a claimant's right to receive compensation and, therefore, is a "matter concerning a claim," presently in existence and subject to litigation.

The majority argues that claimant's right to receive compensation is not directly at issue in the compliance proceeding. It acknowledges that the conclusion of that proceeding "may" affect the claimant's right to receive compensation "at a latter date," but argues that only an indirect relationship exists between the compliance proceeding and claimant's right to receive compensation. In Lasiter v. SAIF, 109 Or App 464 (1991) the Court of Appeals held that the outcome of a proceeding on noncompliance which sets aside a proposed order of noncompliance on the ground that the employer is not a subject employer, necessarily and immediately cuts off claimant's right to receive compensation for his injuries. No additional litigation is required to accomplish that result and any effort claimant may make to establish the compensability of his injury is precluded by the prior determination that the employer is not a subject employer. *Id.* @ 467. The court's resolution of Lasiter leaves no doubt that, when subjectivity is the issue in the compliance proceeding, a claimant's right to receive compensation is immediately, necessarily and directly at issue. To the extent that the aforementioned Board cases, including Derwin W. Wilson, supra, held otherwise, they are incorrect and must be disavowed.

The majority opinion, and each of the specially concurring opinions cite several cases which have been decided by the Court of Appeals. Where the court has acted, and established once and for all the meaning of the law, this body is required to defer to that opinion and to decide the cases before it in a manner consistent with the decision of the court. Consequently, I must address the substance of the opinions cited.

Stare decisis is a fundamental principle of litigation which requires the court, and this Board, to follow principles of law previously established. "Under the doctrine a deliberate or solemn decision of court made after argument on [a] question of law fairly arising in the case, and necessary to its determination, is an authority, or binding precedent in the same court, or in other courts of equal or lower rank." Black's Law Dictionary, 4th Edition, Rev., 1577 (1968). The question, therefore, is whether any of the aforementioned appellate decisions is sufficient to warrant application of the principle.

The first of these cases is Daniel R. Iordison, 42 Van Natta 1946 (1990), aff'd mem 107 Or App 784 (1991). As the citation makes apparent, that Board decision was affirmed by the court without opinion. Because no opinion issued, it is impossible to know whether the court accepted the reasoning provided by the Board, or what the court considers a correct statement of the law to be. The case could have been decided on a basis other than the particular question presented here. It is not the position of the court to advance arguments for the parties. If the party requesting review advanced a theory that,

even if correct, would result in affirmance of the Board's order, that decision will probably be affirmed without opinion. This can occur even though another argument, whether or not apparent to the court, might necessitate a contrary result.

The briefs submitted in the Jordison case demonstrate that the court probably affirmed on this very basis. In that case, the appellant conceded the very issue in dispute here. He conceded to the court that the Director's proceeding is not reviewable by the Board, but, nevertheless, sought Board review arguing that the compensability of the claim had been independently raised and litigated. Thus, Jordison is affirmed on a question of fact, rather than a question of law. In the present claim, I dispute the very concession that was a basis for the decision in Jordison.

In Castle Homes, Inc. v. Whaite, 95 Or App 269 (1989), the court exercised jurisdiction of a direct appeal from a referee's order. However, that exercise of jurisdiction occurred without question. Consequently it appears that no party appearing before the court challenged the court's exercise of jurisdiction, and indeed may have agreed that the court had such jurisdiction. That does not necessarily make it so. Stare decisis applies to a decision resolving a question of law on an issue necessarily arising in the case. In Whaite the court did not resolve a question as to its jurisdiction, because no question or dispute was presented.

Without a doubt the most substantial of the cases relied on by the majority is Ferland v. McMurtry Video Productions, 116 Or App 405 (1992). In that case, each of the elements necessary to warrant application of the principle of stare decisis is unquestionably present. Unfortunately, the substance of that case conflicts with each and every one of the numerous cases previously cited in this opinion, including at least one opinion of the Supreme Court, on the question of what constitutes a matter concerning a claim. In addition the opinion appears to be directly contrary to the Court's earlier opinion in Lassiter, supra.

In Ferland the court reasoned that the Board did not have jurisdiction to review the referee's Opinion and Order regarding noncompliance because "[t]he hearing before the referee on DIF's proposed order concerned only the status of employer. The hearing did not concern claimant's claim, which was being processed by SAIF under ORS 656.054(1)." 116 Or App @ 407. However, in Lasiter v. SAIF, supra, the court stated that "[t]he problem is that, because of the holding in the earlier compliance proceeding, there is not a subject employer against which claimant can claim." 109 Or App @ 467. In Ferland, the Court appears to argue that there is no relationship between the compliance issue and the determination of compensability. In Lasiter, the Court makes clear that there is a relationship and that the determination that the employer is not a noncomplying employer precludes a claim. Both cannot be correct. One of these cases is wrong. Nevertheless, the court in Ferland never addressed the issues raised and discussed in Lasiter and does not disavow, explain, distinguish or overrule the reasoning and resolution of Lasiter. The Court of Appeals, therefore, has provided this body with two cases, each of which satisfy the requirements of stare decisis, and which guide the Board down mutually exclusive paths toward resolution of a single issue. Under these circumstances the principle of stare decisis provides no assistance in the proper resolution of the dispute. The Board must still independently determine and follow the correct interpretation of the statute.

Turning to the facts of this case, claimant filed a claim for compensation for injuries sustained when he was electrocuted while allegedly working for Spencer. The Director initially determined that Spencer was a noncomplying employer and referred the claim to SAIF for processing. The claim was accepted by SAIF, who began paying benefits as required by law. Spencer, thereafter, requested review of the Director's order and a hearing was held resulting in an order finding that Spencer was not a noncomplying employer because claimant was not a subject worker. Because claimant immediately lost his entitlement to receive benefits as a consequence of that order, I would conclude that the Referee's order resolves a "matter concerning a claim" under ORS 656.704(3), and, therefore, we have jurisdiction over claimant's request for review.

The majority's conclusion that the proceeding regarding the putative employer's noncompliance did not involve the compensability of the claim ignores practical reality and is contrary to the court's recent decision in Salter v. SAIF, 108 Or App 717 (1991).

In Salter, the noncomplying employer raised the issue of compensability for the first time orally at a hearing requested to dispute an order of noncompliance. Under those facts, the court held that the Board had jurisdiction to determine both compensability and noncompliance. The present case is similar. Here, in challenging the order of noncompliance by attempting to show that claimant was not a subject worker, Spencer explicitly denied the compensability of the claim, and implicitly challenged SAIF's acceptance of that claim.¹ As it arises in the context of an accepted claim, a challenge to a proposed order of noncompliance on the issue of subjectivity necessarily involves a challenge to the claim itself. If claimant is not a subject worker, he cannot have a compensable claim under the Workers' Compensation Law. Consequently, we have jurisdiction to review the Referee's order under ORS 656.740(4)(c).

In resolving the present dispute I would follow the reasoning in Lasiter and Salter to conclude that the employer had, in fact, implicitly challenged the compensability of the claim. Any other resolution promotes forum shopping. The employer who denies compensability and challenges the Order of Noncompliance in the same proceeding will become a rare bird. The resolution of the second issue may well determine the first and deprive the claimant of the right to de novo review on a matter related to a claim, while failure on the second issue does not preclude the employer's right to challenge the first. Where, as here, the outcome of the case depends upon the findings of credibility the right to de novo review is of substantial, if not critical significance.

For all of the above stated reasons, I respectfully dissent.

¹ The employer's intention to deny the compensability of the claim is further demonstrated in the fact that employer argued only that claimant was not a subject worker. Under these circumstances the referee could, and on the facts of the present claim, probably should have found that employer remained a noncomplying employer regardless of the claimant's subjectivity because he employed other workers, specifically his brother, for remuneration, specifically a house whose value was later established by sale. Because the employer's defense is not adequate to defeat the order of noncompliance the employer, in all practical reality, actually disputed the compensability of the claim.

December 29, 1992

Cite as 44 Van Natta 2530 (1992)

In the Matter of the Compensation of
JOYCE E. STODDARD, Claimant
 ORDER ON REVIEW
 WCB Case Nos. 91-14419, 90-20316 & 91-03626
 Schneider & DeNorch, Claimant Attorneys
 Lundeen, et al., Defense Attorneys
 Schwabe, et al., Defense Attorneys
 Moscato, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

Good Samaritan Hospital, a self-insured employer, requests review of those portions of Referee Menashe's order that: (1) set aside its partial denial of claimant's right radial nerve entrapment condition; and (2) upheld denials of the same condition issued by Fred Meyer, Incorporated and Liberty Northwest Insurance Corporation. Claimant cross-requests review of those portions of the Referee's order that: (1) awarded a \$2,000 assessed attorney fee for his counsel's services at hearing; and (2) declined to assess a penalty for the Good Samaritan's and Fred Meyer's allegedly unreasonable claims processing. On review, the issues are waiver, compensability, responsibility, penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Preliminary Issues

Before we discuss the compensability and responsibility of claimant's radial nerve entrapment condition, we must first address two preliminary issues raised by Good Samaritan. First, it argues that claimant waived her right to assert a claim for her current condition against Good Samaritan when she signed the October 26, 1990 Stipulation and Order, which provides, in part:

"[The January 6, 1990 accepted right wrist claim] will remain in a closed status with all issues which were raised or which could have been raised on or before the date of this settlement is approved by a referee, having been resolved with prejudice." (Ex. 38-5).

Because Dr. Cohen had diagnosed the nerve entrapment condition and requested authorization to perform surgery in September 1990, Good Samaritan argues that claimant could have raised the claim at the time of the stipulation and, consequently, is now precluded from doing so. We disagree.

Claimant waived her right to claim the compensability of her right radial nerve entrapment condition against Good Samaritan only if she intended to waive that right when she signed the stipulation. See David M. Marvin, 42 Van Natta 1778 (1990). Although her treating physician had diagnosed the condition and requested medical services at the time of the stipulation, Good Samaritan had not yet stated its intention whether it would authorize the surgery or deny the September 1990 claim. (Ex. 45). Because the statutory scheme does not permit a hearing on the compensability of a claim prior to an acceptance or denial or prior to the expiration of time in which the carrier may investigate the claim without risking penalties, Syphers v. K-W Logging, Inc., 51 Or App 769 (1981), the compensability of her nerve entrapment condition against Good Samaritan was not yet ripe and, thus, could not have been waived. See Jimmy M. Campo, 42 Van Natta 903 (1990); compare Leola Judson, 42 Van Natta 321 (1990). Accordingly, we agree with the Referee that the October 26, 1990 Stipulation and Order does not affect claimant's right to pursue this matter against Good Samaritan.

Good Samaritan also argues that the Referee lacked jurisdiction to address the issue of its responsibility for claimant's condition, because claimant failed to request a hearing on that issue. We disagree. The record shows that Good Samaritan expressly denied compensability and responsibility for the nerve entrapment condition at hearing. (Tr. 10). Accordingly, the Referee had the authority to address that issue, even if it was not raised in the pleadings. See OAR 438-06-031 (Permitting additional issues to be raised at hearing).

Compensability and Responsibility

The Referee concluded that claimant had established compensability of her right radial nerve entrapment condition and, relying on the opinion of Dr. Cohen, held Good Samaritan responsible. After our review of the record, we agree and adopt the Referee's conclusions and reasoning. We add the following supplementation.

On review, Good Samaritan argues that Fred Meyer assumed responsibility for claimant's current right wrist condition when it accepted her April 30, 1990 injury claim. It relies on ORS 656.308(1), which 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."

Good Samaritan's reliance on that provision is misplaced. The record shows that claimant's April 30, 1990 compensable injury with Fred Meyer was reported, treated and accepted as a right wrist strain, which, based on the persuasive opinion of Dr. Cohen, had no effect on claimant's right radial nerve entrapment condition resulting from her prior injury at Good Samaritan. Because the injury sustained at Fred Meyer injury did not involve the same condition as the one at issue here, we conclude that ORS 656.308(1) is not applicable. See generally Beverly R. Tillery, 43 Van Natta 2470 (1991).

Penalties

We adopt the Referee's conclusion and reasoning concerning this issue.

Attorney Fees

The Referee awarded claimant's counsel an assessed fee of \$2,000 for services rendered in prevailing against Good Samaritan's denial. Claimant contends that the award is inadequate and should be increased.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we conclude that \$2,000 adequately and reasonably compensates claimant's counsel for services at hearing regarding the partial denial. 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.

Additionally, on review, after considering the same factors set forth in OAR 438-15-010(4) and considering the time devoted to the case as represented by claimant's respondent's brief (with the exception of the penalty and attorney fee issues), we find that a reasonable fee for claimant's counsel's services on review is \$750, to be paid by Good Samaritan.

ORDER

The Referee's order dated February 20, 1992 is affirmed. For services on Board review, claimant's attorney is awarded an assessed fee of \$750, to be paid by Good Samaritan.

December 29, 1992

Cite as 44 Van Natta 2532 (1992)

In the Matter of the Compensation of
SUSAN N. TODD, Claimant
WCB Case No. 92-03294
ORDER OF ABATEMENT
Olson, Rowell & Walsh, Claimant Attorneys
Rick Dawson (Saif), Defense Attorney

On December 3, 1992, we 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. Noting that the parties have agreed to settle this matter, claimant seeks abatement of our order so we may retain jurisdiction to consider their proposed agreement.

In light of such circumstances, we withdraw our December 3, 1992 order. Upon receipt of the parties' proposed agreement, we will proceed with our review of that agreement. 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
JEFFREY A. VILES, Claimant
WCB Case No. 91-14438
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Mitchell, et al., Defense Attorneys

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of that portion of Referee Crumme's order that found that claimant was not entitled to additional temporary total disability because his aggravation rights had expired. On review, the issue is temporary total disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Applicable Law

Claimant contends that the law in effect at the time of his injury applies to this case rather than the current law. We disagree.

Claimant requested a hearing after May 1, 1990, and the hearing was convened after July 1, 1990. Therefore, the "litigation savings clause" contained in §54 (2) does not apply. In addition, 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). However, because claimant was found medically stationary prior to July 1, 1990, the 1990 amendments, with the exception of those statutes specifically listed in §54 (3), apply to claimant's claim.

Aggravation Date

The Referee found that claimant was barred by res judicata from now asserting that his aggravation rights ran from a date other than the date of his injury. We agree with the Referee's ultimate conclusion that claimant's aggravation rights ran from the date of his January 1983 nondisabling industrial injury, but we base our decision on the following reasoning.

On review, claimant contends that since there is no evidence that the carrier closed his nondisabling claim, his aggravation rights run from the date of the June 24, 1988 Determination Order (which closed a subsequent aggravation claim). We disagree.

ORS 656.273(4)(b) provides: "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). Pursuant to the statute, claimant's aggravation rights ran from the date of injury since his claim was in nondisabling status from the beginning and remained so for more than a year. See SM Motor Co. v. Mather, 117 Or App 176 (1992). Moreover, this was also the rule under the law prior to the 1990 amendments when, as here, there was no contention that the claim had been misclassified from the outset. See, e.g. former ORS 656.273(4)(b); Davison v. SAIF, 80 Or App 541 (1986); Smith v. Ridgepine, Inc., 88 Or App 147 (1987); Gary I. Armstrong, 43 Van Natta 976 (1991); Darold W. Miller, 42 Van Natta 2296 (1990). Accordingly, claimant's aggravation rights expired on January 7, 1988, five years from the date of the industrial injury.

ORDER

The Referee's order dated March 5, 1992 is affirmed.

In the Matter of the Compensation of
JOANNE M. ELL, Claimant
WCB Case No. 91-14067
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Charles A. Ringo, Defense Attorney

Reviewed by Board Members Kinsley and Hooton.

Claimant requests review of Referee Black's order that upheld the insurer's denial of claimant's aggravation claim for a low back condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for the last paragraph and his "Findings of Ultimate Fact," with the following supplementation.

Claimant's compensable December 1990 injury was a material contributing cause of her worsened low back condition and need for surgery.

An "off work" injury was not the major contributing cause of claimant's worsened low back condition.

CONCLUSIONS OF LAW AND OPINION

Interpreting amended ORS 656.273(1) to place the burden on claimant to prove that her worsened condition was not due, in major part, to an off-the-job injury, the Referee concluded that claimant failed to carry her burden and, therefore, had failed to establish a compensable aggravation claim. On review, claimant argues that the insurer bears the burden of proving that an off-the-job injury was the major contributing cause of her worsened condition. We agree.

In Roger D. Hart, 44 Van Natta 2189 (1992), a decision rendered subsequent to the Referee's order, we recently decided the issue of which party has the burden of proof regarding the contribution of an off-the-job injury in an aggravation case. We found that, under ORS 656.266, claimant has the burden of proving that the compensable injury is a material contributing cause of the worsened condition. Elizabeth A. Bonar-Hanson, 43 Van Natta 2578 (1991), aff'd mem Bonar-Hanson v. Aetna Casualty Company, 114 Or App 233 (1992). However, we also found that if, pursuant to ORS 656.273(1), the insurer denies the aggravation claim on the grounds that an off-the-job injury is the major contributing cause of the worsened condition, as the proponent of that fact, the insurer has the burden of proving it. Roger D. Hart, supra.

Here, claimant credibly testified that, following her compensable injury in December 1990 and subsequent surgery in March 1991, she continued to experience discomfort and restrictions. (Tr. 7). Then, in August 1991, she helped a young neighbor start her lawn mower so that he could mow her lawn. (Tr. 8). After starting the lawn mower, claimant experienced no pain. (Id.). However, the next morning she experienced low back pain and sought treatment from Dr. Brooks, her treating physician. (Tr. 8; Ex. 4-5). Dr. Brooks prescribed medication and complete bedrest and referred claimant back to Dr. Matteri, her treating surgeon. (Id.). Dr. Matteri ordered an MRI and diagnosed recurrent disc herniation at the L4-5 level. (Tr. 8; Ex. 14). Both Dr. Brooks and Dr. Matteri attributed claimant's worsened condition to her original compensable injury. (Ex. 17, 18). The insurer denied claimant's aggravation claim, asserting that it was caused by an off-the-job injury. (Ex. 16).

On this record, we find that claimant has carried her burden of proving that her compensable injury was a material contributing cause of her worsened condition and need for treatment. Consequently, under amended ORS 656.273(1), the question now becomes whether, based on the medical evidence, the insurer carried its burden of proving its assertion that an off-the-job injury was the major contributing cause of claimant's worsened condition.

This issue presents a complex medical question requiring expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985); rev den 300 Or 546 (1986). We generally give greater weight to the conclusions of

the treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find no persuasive reason not to defer to the opinions of Dr. Brooks and Dr. Matteri.

Dr. Brooks opined that claimant's original injury was the major contributing cause of her recurrent herniated disc at level L4-5. (Ex. 17). Moreover, Dr. Matteri, also attributed claimant's worsened condition solely to her original injury. (Ex. 18). On the other hand, Dr. Woolpert, who performed an independent medical file review, opined that claimant's worsened condition was specifically caused by her efforts to start the lawn mower. (Ex. 19-3). The Referee concluded that the opinions of Dr. Brooks and Dr. Matteri were unpersuasive and relied, instead, on the opinion of Dr. Woolpert because he found it to be based on a more complete history. We disagree.

To begin, Dr. Woolpert did not examine claimant and his opinion is based entirely on his understanding of a file review of the opinions and reports generated by Dr. Brooks and Dr. Matteri. (Tr. 2; Ex. 19-1). It is, therefore, impossible for him to have a more complete history than claimant's treating physicians. Furthermore, Dr. Woolpert's understanding of the medical file is incorrect. He assumes that claimant experienced an acute onset of disability following the incident with the lawn mower. However, claimant's testimony was that she experienced no symptoms at the time of the incident and that symptoms developed the next day, causing her to seek treatment from Dr. Brooks. (Tr. 8).

Consequently, we do not find Dr. Woolpert's opinion persuasive. Therefore, we conclude that, because the insurer failed to carry its burden of proving its assertion that an off-the-job injury was the major contributing cause of claimant's worsened condition, claimant has established the compensability of her aggravation claim.

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 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 insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the appellate briefs and the record), the complexity of the issue, the value of the interest involved and the risk that claimant's attorney's efforts would go uncompensated in this case.

ORDER

The Referee's order dated March 19, 1992 is reversed. The insurer's aggravation denial is set aside, and the claim is remanded to the insurer 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 insurer.

December 30, 1992

Cite as 44 Van Natta 2535 (1992)

In the Matter of the Compensation of
WILLIS D. FERRELL, JR., Claimant
 WCB Case Nos. 91-01827 & 91-01826
 ORDER ON REVIEW
 Lundeen, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Kinsley.

Claimant, pro se, requests review of Referee Gruber's order which: (1) upheld the insurer's denial of claimant's heart attack in November 1989; (2) upheld the insurer's denial of claimant's nosebleeds in June 1990; and (3) declined to assess penalties for the insurer's alleged failure to process the claims in a timely manner. Along with his appellant's brief, claimant submitted additional evidence which he asserts should have been submitted at hearing. On review, the issues are motion to remand, compensability and penalties. We deny the motion to remand and affirm.

FINDINGS OF FACT

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

In lieu of the last sentence of the first paragraph of factual findings, we make the following finding:

Claimant performed the job "hot"; that is, while the wires continued to carry electrical current.

In lieu of the last sentence of the fourth paragraph of factual findings, we make the following findings:

Claimant testified that he mentioned the electrical shocks to Dr. Robinhold about four days after his hospital admission. (Tr. 50). However, Dr. Robinhold's chart notes contain no indication that claimant discussed his exposure to electrical shocks with him. (See Exs. 1, 2, 5, 12-1).

We add the following finding to the sixth paragraph of factual findings:

Claimant also testified to this conversation, indicating that Mr. Stapleton had asked whether he (claimant) had been electrocuted and thrown off the building, and claimant replied that he had gotten "a lot of shocks," but had not been electrocuted. (Tr. 53).

CONCLUSIONS OF LAW AND OPINION

Motion to Remand

Claimant submitted additional documents appended to his appellant's brief, which were not in the record at the hearing. We treat their submission by claimant as a motion to remand to the Referee for the admission of additional evidence.

We may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Olson, 37 Van Natta 1054, 1055 (1986), aff'd mem, 80 Or App 152 (1986). We consider the proffered evidence only to determine whether remand is appropriate.

Enclosed with his appellant's brief, claimant has submitted the following materials: (1) a copy of the annotated statutes from ORS Chapter 656; (2) a list of job sites where claimant worked with "hot" electrical wires; (3) claimant's pay stubs from his employer for the months of September, October, and December 1990; (4) a November 1991 letter from claimant to the insurer's counsel concerning the "Master Exhibit List" submitted at the May 1991 hearing; (5) correspondence (circa March and April 1991) between the Oregon Occupational Safety and Health Division and claimant's employer regarding potential safety hazards (working around "hot" wires in unsafe circumstances); (6) a March 1991 article from the publication Plant Services entitled "Electrical Safety for the Plant"; (7) an undated research paper from "Electro Test, Inc." entitled "Electrical Accident Reporting"; (8) correspondence (circa November 1991 and December 1991) between claimant and Dr. Grossman which included eight articles regarding electrical injuries and their effect on the heart.

The insurer objects to claimant's submission of these materials on review. Noting that none of these documents were admitted into evidence at the hearing, the insurer moves to strike them from claimant's appellant's brief. To the extent that the submission is interpreted as a motion to remand to the Referee for further evidence taking, the insurer contends that the record has not been insufficiently, incompletely, or improperly developed. Therefore, the insurer argues that remand is not appropriate.

To begin, we do not consider claimant's submission of the annotated version of the workers' compensation statute (ORS Chapter 656) to be evidence. Rather, such a submission is interpreted as a presentation of legal citations in support of his argument that his claims are compensable. Consequently, this portion of claimant's submission shall be considered on review.

Secondly, a copy of his November 1991 letter to the insurer's counsel regarding the exhibit list is already in the record. This correspondence pertains to a processing question which arose during the briefing schedule. The matter has no effect on the merits of claimant's appeal. Therefore, this portion of claimant's submission shall likewise not be stricken from claimant's brief.

The 1990 pay stubs, the March-April 1991 OSHA correspondence, and the March 1991 Plant Services article were all in existence prior to the May 1991 hearing. Inasmuch as it has not been clearly shown why these materials were not obtainable at the time of the hearing, we conclude that remand is

not justified. Moreover, we do not consider the record without these materials to have been improperly, incompletely, or otherwise insufficiently developed. See ORS 656.295(5).

The list of job sites and the "Electrical Accident Reporting" research report are undated. Thus, it is not readily apparent whether such materials were in existence at the time of the hearing. Nevertheless, since no showing has been made concerning whether these materials were unobtainable at the hearing with the exercise of due diligence, we are not persuaded that remand is justified. Likewise, without the submission of these materials, we do not consider the record to have been improperly, incompletely, or otherwise insufficiently developed. See ORS 656.295(5).

Finally, Dr. Grossman's December 1991 letter was generated subsequent to the hearing. Therefore, this letter was not obtainable at the time of hearing. However, the letter merely acknowledges that the physician was asked about the eight "electrical injury - heart problem" articles (referred to in claimant's November 1991 letter to the physician) during his deposition. Inasmuch as Dr. Grossman's opinion is already in the record, we consider this post-hearing submission to be cumulative. Consequently, we do not find the present record (without Dr. Grossman's December 1991 letter) to be improperly, incompletely, or otherwise insufficiently developed. Accordingly, we decline to remand for the introduction of this letter.

The eight articles were relied on by medical experts Drs. Herbert and Grossman. Yet, the record already contains explanations of the basis for these physicians' opinions, including reference to the submitted articles. (See Ex. 30-11 to 30-18; Ex. 31-18 to 31-21). Therefore, we do not find the record to be improperly, incompletely, or otherwise insufficiently developed without these articles.

Moreover, we find that the articles were available and obtainable well before the record closed. The articles were referenced in the opinion letters of Drs. Herbert and Grossman (Exs. 25, 26), and they were available at the doctors' depositions as well. An attorney's decision not to produce evidence that is otherwise available prior to hearing is not grounds for remand. See Kirk D. Myers, 42 Van Natta 2757 (1990). For these reasons, claimant's motion to remand is denied.

Compensability of heart attack

Claimant's theory of the compensability of the heart attack he suffered on November 6, 1989 turns on his assertion that he suffered a series of electrical shocks while working, prior to his heart attack. The Referee found that all witnesses, including claimant, testified credibly, based on his observation of their demeanor at the hearing. Nevertheless, based on conflicts between credible testimony and the fact that the first documented mention of electrical shocks was in the workers' compensation claim filed in February 1991, the Referee found the substance of claimant's testimony to be not credible. Because the Referee concluded that claimant did not experience a series of electrical shocks prior to his heart attack, he held that the heart attack was not compensable. We agree with the Referee's conclusion, but we apply the following reasoning.

First, we find that because 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, §54; see Ida M. Walker, 43 Van Natta 1402 (1991).

Although the Referee found that claimant had preexisting coronary artery disease unrelated to his employment, he analyzed this case as an industrial injury and held that claimant's burden was to establish that his work activities were a material contributing cause of his heart attack in order to prove compensability.

Subsequent to the Referee's order we held that, in cases involving preexisting conditions, the determination of whether a claim is compensable requires 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. ORS 656.005(7)(a). Second, if it is determined that there is a preexisting condition that 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).

With respect to the first part of the test, we agree with the Referee's conclusion that claimant failed to establish by a preponderance of the evidence that he sustained a series of electrical shocks while working on November 6, 1989. The Referee determined that claimant's testimony was not credible, based on substantive inconsistencies in the record. We defer to the Referee's credibility evaluation based on his observation of the witnesses' demeanor at hearing, but we independently evaluate claimant's credibility based on the substance of his testimony. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

After our review of the record, we conclude that claimant failed to prove that he was exposed to a series of electrical shocks while working. Claimant testified that he notified his employer of these electrical shocks and their relationship to his heart problem shortly after his hospitalization. While we do not find a direct conflict in testimony, we note that only claimant's wife corroborated claimant's testimony that he was exposed to a series of electrical shocks. The remaining portions of the record do not support claimant's contention.

Claimant's employer, Fred Wittkop, testified that when he visited claimant in the hospital, a few days after the myocardial infarction (MI), Wittkop asked claimant if he had been shocked, and claimant replied, "No." (Tr. 136-37). Wittkop also asserted that he did not recall discussing workers' compensation coverage for the MI with claimant at that time. (Tr. 138-39).

Claimant also recounts the conversation with Wittkop, but does not mention discussing electrical shocks. However, claimant asserts they discussed workers' comp coverage, and Wittkop told him the MI would not be covered, since it's an "illness" not an "injury." (Tr. 33-34).

The only co-worker with whom claimant definitely discussed electrical shocks was Al Stapleton. Claimant testified on cross-examination that Stapleton told him he feared claimant had been electrocuted and thrown off the building. Claimant testified that he told Al that he had not been electrocuted per se; he had gotten a lot of shocks, but was not electrocuted. (Tr. 53). Stapleton testified that in response to his question, claimant said he was not shocked. (Tr. 83-84).

Claimant also testified that he mentioned receiving electrical shocks when he conversed with Dr. Robinhold, his treating cardiac physician, after the MI and before discharge. (Tr. 50-51). However, there is no mention of exposure to electrical shocks in any of Dr. Robinhold's notes. In fact, the first documentation supporting a relationship between claimant's work exposure to electrical shocks was in claimant's workers' compensation claim filed in February 1991, over a year after the alleged exposure and claimant's heart attack.

In light of the aforementioned contrary testimonial and documentary evidence, we find that claimant's testimony and his wife's corroboration regarding whether claimant experienced electrical shocks while working has been significantly undermined. Consequently, we are not persuaded that claimant was exposed to a series of electrical shocks at work which resulted in his MI and ensuing hospitalization.

Accordingly, we find that claimant did not sustain a compensable injury pursuant to ORS 656.005(7)(a). We, therefore, need not reach the question of whether the compensable injury remained the major contributing cause of claimant's resultant condition under ORS 656.005(7)(a)(B).

Compensability of nosebleeds

We adopt the Referee's order with regard to this issue.

Penalties

We adopt the Referee's order with regard to this issue.

ORDER

The Referee's order dated August 21, 1991 is affirmed.

In the Matter of the Compensation of
PAULA J. GILMAN, Claimant
WCB Case No. 91-14264
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Hooton.

The SAIF Corporation requests review of Referee Herman's order which: (1) awarded claimant benefits for 15 percent (22.5 degrees) scheduled permanent disability for loss of use or function of her right leg and foot, whereas the Order on Reconsideration awarded benefits for 3 percent (4.5 degrees) scheduled permanent disability; and (2) directed it to pay claimant's scheduled permanent disability 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," except for her finding on page 3 of the "Conclusions of Law and Opinion" section that, at the time of closure, claimant did not have an attending physician. We also supplement her findings as follows.

At the time of claim closure, Dr. Collada was claimant's attending physician.

CONCLUSIONS OF LAW AND OPINION

Impairment

The Referee found that, at the time of claim closure, claimant did not have an attending physician and that no medical arbiter had been appointed. However, the Referee determined that, based on the preponderance of the medical evidence, claimant was entitled to a total rating of 15 percent for her vascular impairment in the right leg and foot. While we agree with the Referee's ultimate conclusion, we disagree with the Referee's finding that claimant did not have an attending physician at closure. Accordingly, we substitute the following analysis.

ORS 656.005(12)(b) defines an "attending physician" as "a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury." Additionally, ORS 656.245(3)(b) and ORS 656.268(7) state that only the attending physician at the time of closure, or a medical arbiter appointed by the Director on reconsideration of a determination order, may make findings regarding a claimant's impairment for the purpose of evaluating disability. However, former OAR 436-35-007(8) (WCD Admin. Order 2-1991), which applies to the rating of claimant's scheduled permanent disability here, allows impairment findings made by a consulting physician or other medical providers at claim closure to be used in determining impairment, if claimant's attending physician concurs with the findings.

Whether a physician qualifies as an "attending physician" at the time of claim closure, so that the physician's impairment findings or concurrence with other physicians or providers may be used in determining impairment, is a question of fact.

Here, claimant initially named Dr. May as her "attending physician" in her 801 Form. (Ex. 1). However, Dr. May subsequently referred claimant to Dr. Collada for evaluation of her vascular condition. (Ex. 12). Dr. Collada evaluated claimant and recommended a lumbar sympathectomy, which he performed on August 3, 1990. (Ex. 14). Thereafter, Dr. Collada continued to treat claimant for her vascular condition. (Ex. 39). Moreover, Dr. Collada's name appears on all consulting physician reports, including those of Dr. Moore (Ex. 14), Dr. French (Exs. 16, 30), Dr. Johnson (Ex. 20), Dr. Girod (Ex. 23), Dr. Wilson (Ex. 24), Dr. Sund (Exs. 26, 29) and Dr. Chester (Exs. 41, 42, 46). In addition, on January 10, 1991, Dr. Burchiel, a consulting physician, wrote to Dr. Collada regarding claimant, stating that he had the opportunity to see "your patient." (Ex. 47). Furthermore, Dr. Collada reported to SAIF regarding the progress of claimant's treatment. (Exs. 19, 56).

We find, on these facts, that Dr. Collada was primarily responsible for the treatment of claimant's compensable condition, beginning in July 9, 1990. While there is some indication that in May 1991, Dr. Collada was not actively treating claimant, at that time claimant was medically stationary. (Ex. 53, 54, 56). Consequently, we also find that, at the time of claim closure on July 8, 1991 (Ex. 62), Dr. Collada was claimant's attending physician.

Turning to the evidence of impairment, we find that prior to claim closure on May 1, 1991, Dr. Bachulis performed an independent medical examination wherein he found "mild pitting edema bilaterally" and determined that claimant was medically stationary. (Ex. 55-7). He also noted that claimant's edema and accompanying pain was too severe for her to wear support hose. (Ex. 55-7). On May 25, 1990, responding to a request by SAIF and in response to Dr. Bachulis' report, Dr. Collada concurred and opined that claimant had permanent impairment, although it was minimal. (Ex. 56).

Former OAR 436-35-230(6)(b)(C) allows a 15 percent impairment rating for edema which is only partially controlled by support hose. Consequently, we conclude, based on Dr. Collada's impairment findings and his ratification of Dr. Bachulis' findings, that claimant is entitled to an additional 12 percent scheduled permanent disability beyond the 3 percent order on reconsideration award for her right leg and foot vascular condition. Therefore, the Referee's order awarding claimant a total of 15 percent scheduled permanent disability is affirmed.

Claimant is entitled to an assessed attorney fee for prevailing over SAIF's request for Board review on the issue of extent of scheduled permanent disability. Following consideration of the factors outlined in OAR 438-15-010(4), we find that a reasonable attorney fee is \$750, to be paid by SAIF. We have particularly considered the time devoted to the case, the complexity of the issue, and the value of the interest involved.

Rate Per Degree

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), where 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 April 9, 1992 is reversed in part and affirmed in part. That portion of the Referee's order which direct the SAIF Corporation to pay claimant's scheduled permanent disability award at the rate of \$305 per degree and awarded an attorney fee payable from the increased compensation is reversed. SAIF 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 order is affirmed. For services on Board review, claimant is awarded an assessed attorney fee of \$750, to be paid by SAIF.

In the Matter of the Compensation of
RONALD M. HARVEY, Claimant
WCB Case Nos. 91-13868 & 89-16316
ORDER ON REVIEW
Gerald R. Hayes, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney
Bailey & Associates, Attorneys

Reviewed by Board Members Kinsley and Brazeau.

The noncomplying employer (NCE) requests review of those portions of Referee Bethlahmy's order that: (1) found claimant's 1988 low back injury to be compensable; and (2) upheld the SAIF Corporation's aggravation denial (on behalf of Evergreen Roofing) for the same condition. On review, the issues are compensability and responsibility. We affirm.

PROCEDURAL STATUS

We adopt the Referee's statement of the procedural status of the case with the following additions.

On June 7, 1989, SAIF accepted claimant's claim against the NCE. (Ex. 34). On August 1, 1989, the NCE requested a hearing on SAIF's acceptance, raising the issues of compensability and responsibility. (Ex. 39). On February 1, 1990, the NCE moved to join SAIF (Evergreen) as a necessary party.

In its June 25, 1991 Order on Review (Remanding), the Board found that the issues of compensability, joinder and responsibility had been before the prior referee. Ronald M. Harvey, 43 Van Natta 1418 (1991). The Board vacated the April 20, 1991 Opinion and Order, remanding the case back to the Hearings Division. By a September 27, 1991 Order of Joinder, the Hearings Division granted the NCE's motion to join SAIF (Evergreen) and directed the matter to be set for hearing. The case was heard on January 2, 1992.

FINDINGS OF FACT

We adopt the Referee's findings of fact, with the exception of the fifth paragraph on page two, and as supplemented herein.

Claimant has an underlying, preexisting condition diagnosed as epiphysitis (Scheuermann's disease) of the thoracic and upper lumbar area. (Exs. 6-3, 16-1 and 18-3). Tests for suspected spondyloarthropathy proved negative in 1987. (Ex. 8-1).

Claimant was off work for his two 1986 injuries for one month and 44 days, respectively. He was diagnosed with severe low back pain without radiculopathy after each injury. (Ex. 2).

In September 1986, Dr. Gray, who was claimant's treating physician at that time, opined that claimant had no protruded disc or nerve-root injury. On the basis of a CT scan, he reported that claimant had a minor, but not abnormal, narrowing of the L4-5 disc. He diagnosed claimant with a chronic low back strain, as did Dr. Benz, orthopedist, who performed an independent medical examination in June 1987. (Exs. 4-2 and 6-3).

Dr. Cowan continued to provide chiropractic treatment for claimant's chronic lumbar strain through November 1988. (Ex. 2).

In February 1989, Dr. Hathaway reported new symptoms of bilateral leg pain into the heel, which, he opined, resulted from an injured L4-5 disc with radiculopathy. (Ex. 18).

FINDINGS OF ULTIMATE FACT

August 1, 1989 and February 1, 1990 were the dates of requests for hearing on the issues of compensability, joinder and responsibility. A hearing was convened on those issues on March 19, 1990.

Claimant's December 15, 1988 low back injury, which arose out of and in the course of employment, was a material contributing cause of his disability and need for medical treatment.

The December 15, 1988 injury independently contributed to the pathological worsening of claimant's underlying low back condition.

CONCLUSIONS OF LAW AND OPINION

We affirm the Referee's order with supplementation. As a preliminary matter, we address the issue of the applicable law. Although this issue was not raised by the parties, we address it under our power of de novo review.

Applicable Law

The Referee concluded that both compensability and responsibility should be determined under the Workers' Compensation Law as amended effective July 1, 1990, reasoning that, although the initial hearing was convened prior to July 1, 1990, the consolidated hearing convened after July 1, 1990. We disagree.

Section 54 of Oregon Laws (1990), chapter 2 provides in pertinent part:

"(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."

Subsequent to the Referee's order, we recently concluded in Eler M. Cousin, 44 Van Natta 2285 (1992), that the date of a request for hearing on a specific issue and the date on which a hearing is convened on that same issue are the relevant dates for establishing whether the law prior or subsequent to the 1990 amendments should be applied.

Here, the NCE requested a hearing on August 1, 1989, raising the issues of compensability and responsibility. The NCE moved to join Evergreen on February 1, 1990, prior to the hearing that was convened on March 19, 1990. In its June 25, 1991 Order on Review (Remanding), the Board found that the issues of compensability, joinder and responsibility had been before the referee at the March 19, 1990 hearing. Ronald M. Harvey, supra. The Board vacated the April 20, 1991 Opinion and Order and remanded the entire matter back to the Hearings Division. After the Hearings Division issued an order granting the NCE's motion to join SAIF (Evergreen), the remaining issues of compensability and responsibility came before the Referee in this case.

We find that August 1, 1989 and February 1, 1990 were the dates of requests for hearing on the issues of compensability, joinder and responsibility and that a hearing was convened on those three issues on March 19, 1990. The NCE's subsequent appeal to the Board on the issue of joinder, the Board's remand, the Order of Joinder, and the January 2, 1992 hearing on compensability and responsibility all relate back to the NCE's initial request for hearing. Furthermore, although the Order of Joinder resulted in a new "request for hearing" and a new WCB claim number, these were for the administrative convenience of the Hearings Division and were not in response to a hearing request on an issue that was not raised in the initial request for hearing. See Eler M. Cousin, supra.

Accordingly, because the request for hearing on compensability and responsibility was filed before May 1, 1990, and a hearing was convened before July 1, 1990, the matter must be determined pursuant to the law in effect before July 1, 1990. Or Laws 1990 (Special Session), ch. 2, §54; Eler M. Cousin, supra.

Compensability

In order to establish the compensability of his low back injury, claimant must prove that the December 15, 1988 incident while he was unloading trees for the employer was a material contributing cause of his disability or need for treatment. See Hutcheson v. Weyerhaeuser, 288 Or 51, 56 (1979). Claimant has the burden of proving his contentions by a preponderance of the evidence. ORS 656.266; Hutcheson v. Weyerhaeuser, supra. After reviewing the record, we conclude that claimant has sustained his burden of proof.

In 1986, claimant experienced two compensable low back injuries while employed by Evergreen. The injuries caused chronic, recurrent low back strain without radiculopathy. After the second 1986

injury, claimant treated with Dr. Cowan, chiropractor, for low back pain on a regular basis through November 1988. During this period, claimant complained on only two occasions of cramping in both thighs and radiating pain into the right leg.

On December 15, 1988, while working for the NCE, claimant experienced a "pop" in his low back after he attempted to pull balled trees from a truck while making a delivery in California. He was taken by ambulance to a nearby hospital emergency room, where he reported low back pain without radiation. He was treated conservatively. After being driven back to Oregon, claimant again sought treatment from Dr. Cowan, who noted recurrent leg pain and numbness. (Ex. 1-6). On February 23, 1989, Dr. Hathaway, chiropractor, Dr. Fuller, orthopedist, and Dr. Peterson, neurologist, performed an independent medical examination. They diagnosed a probable L4-5 central disc protrusion with radicular symptoms. The doctors opined that claimant sustained a new injury that worsened claimant's chronic lumbar strain as well as a worsening or injury to the disc itself. (Exs. 18 and 25). They also opined that the injury worsened claimant's "preexisting condition."

Based on the circumstances of claimant's injury, emergency room report, and these contemporaneous medical opinions, we conclude that the December 15, 1988 incident while claimant was unloading trees for the NCE was a material contributing cause of his disability or need for treatment.

Responsibility

Responsibility for claimant's compensable low back condition remains with SAIF (Evergreen), who has the last compensable claim, unless it can prove that the compensable injury at the NCE independently contributed to the worsening of claimant's underlying condition. Hensel Phelps v. Mirich, 81 Or App 290, 294 (1986).

As noted above, after the 1986 injuries, Dr. Cowan reported only low back complaints, with the exception of two brief mentions of leg cramps and thigh numbness. After the December 15, 1988 injury, Dr. Cowan reported recurrent leg pain and numbness. Based on claimant's reports of leg pain and their findings upon examination, Drs. Hathaway, Fuller, and Peterson diagnosed a probable L4-5 central disc protrusion with radicular symptoms and opined that claimant sustained a new injury that worsened his "preexisting" condition. They elaborated their opinion by explaining that claimant experienced a symptomatic worsening of his chronic lumbar strain and an additional worsening or injury to the disc itself. (See exs. 18 and 25). They also identified an underlying and preexisting epiphysitis of the thoracic and upper lumbar area, which, they opined, was not producing claimant's current symptoms. (Ex. 18).

We find the opinion of Drs. Hathaway, Fuller, and Peterson to be more persuasive than those of Dr. Franks, neurosurgeon, who first examined claimant on December 8, 1989, and Dr. Jessen, neurologist, who examined claimant on January 11, 1990. Franks opined that claimant probably had a bulging disc prior to the 1988 injury. This opinion is not borne out by the contemporary medical reports and tests. Jessen's opinion that the December 15, 1988 incident was "merely an exacerbation of claimant's pre-existing condition for which he had received consistent chiropractic treatment" was based on her conclusion that there was no objective evidence of worsening in the various diagnostic studies done over a three-year period and no evidence of any neurological problems. (Ex. 47). This conclusion is also not borne out by the medical evidence outlined above.

We, accordingly, conclude that the compensable injury at the NCE independently contributed to the worsening of claimant's underlying condition.

Claimant is entitled to an assessed attorney fee for prevailing over the request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is \$1,000, to be paid by the SAIF Corporation on behalf of the NCE. 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 February 3, 1992 is affirmed. For services on Board review, claimant's counsel is awarded an assessed attorney fee of \$1,000, to be paid by the SAIF Corporation on behalf of the noncomplying employer.

In the Matter of the Compensation of

WALTER R. OLINGER, Claimant

WCB Case No. 91-13065

ORDER ON REVIEW

Francesconi & Associates, Claimant Attorneys

Randolph Harris (Saif), Defense Attorney

Reviewed by Board Members Brazeau and Kinsley.

Claimant requests review of that portion of Referee Bethlahmy's order which found that his claim had not been prematurely closed. Alternatively, claimant argues that his present condition is a compensable aggravation of his original claim for a low back condition. On review, the issues are premature closure, and if the claim was not prematurely closed, aggravation. We reverse in part and vacate in part.

FINDINGS OF FACT

We adopt the Referee's "Findings of Fact," except for the second to the last sentence in paragraph one and paragraph six on page 3, and substitute the following.

In his June 14, 1991 report, Dr. Berkeley noted a significant increase in pain and new symptoms, found it was necessary to re-evaluate claimant's condition and ordered an MRI scan to determine whether aggressive treatment was required.

Following an October 24, 1991 independent evaluation, Dr. Seres noted improvement since the Summer and anticipated further improvement in claimant's condition in the future.

On August 5, 1991, the date of claim closure, further material improvement in claimant's accepted condition was reasonably expected from medical treatment or the passage of time.

CONCLUSIONS OF LAW AND OPINIONPremature Closure/Aggravation

The Referee declined to rely on the subsequent opinion of Dr. Berkeley, claimant's attending physician, and found that claimant was medically stationary as of June 1991. Consequently, the Referee concluded that claimant's claim was not prematurely closed by the August 1991 Determination Order. 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 5, 1991 Determination Order. Claimant's condition is considered as of the time of closure without regard to subsequent changes in his condition. 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 upon competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981).

The record contains the medical opinions of Dr. Berkeley and Dr. Seres, who performed an independent medical evaluation. Dr. Berkeley re-evaluated claimant on June 14, 1991 and noted a significant increase in the pain radiating down claimant's right leg and, for the first time, pain in claimant's left calf with some electrical sensation but no burning sensation. (Ex. 24-1). While he stated that claimant was medically stationary on June 14, 1991, Dr. Berkeley also requested authorization to proceed with a Magnevist enhanced MRI scan of claimant's lumbar spine to determine if more aggressive treatment was needed. (Exs. 24-2, 25). On July 12, 1991, Dr. Berkeley opined that claimant's condition had worsened and was not medically stationary. (Ex. 27). Dr. Berkeley subsequently stated that claimant had not been medically stationary on June 14, 1991, as well. (Ex. 44-2).

Additionally, Dr. Seres, a physician at the pain center where claimant received treatment in 1988, indicated following an October 24, 1991 evaluation that since claimant had improved since the Summer of 1991, Seres expected further improvement in claimant's condition with time. (Ex. 41-4). Moreover, Dr. Seres later concurred that claimant was not medically stationary in June 1991 and that an

MRI scan was warranted. (Ex. 46). The opinions of Dr. Berkeley and Dr. Seres regarding claimant's medically stationary status are uncontroverted.

The Referee declined to rely on Dr. Berkeley's post-closure opinion that claimant was not medically stationary on June 14, 1991 because Dr. Berkeley did not explain the reason for the reversal of his earlier opinion. We find that Dr. Berkeley's change of opinion is explained by his decision to re-evaluate claimant's condition and his recommendation for an MRI scan to determine if more aggressive treatment was warranted. Moreover, shortly after his earlier opinion, Dr. Berkeley indicated that claimant was not medically stationary and cited objective findings supporting his opinion. Finally, as previously noted, Dr. Berkeley's post-closure opinion that claimant was not medically stationary is supported by that of Dr. Seres, who expected claimant's condition to further improve with time.

Based on the opinions of Drs. Berkeley and Seres, we conclude that claimant's claim was prematurely closed by the August 5, 1991 Determination Order.

Moreover, because we have found that the claim was prematurely closed, we also find that the compensability of claimant's aggravation claim is moot. Consequently, we vacate that portion of the Referee's order which upheld the SAIF Corporation's denial of claimant's aggravation claim.

Offset

The Referee concluded that SAIF had proven its entitlement to an offset for overpayment of temporary disability benefits in the amount of \$9,259.32. We agree that SAIF is entitled to an offset in that amount. However, the Referee failed to indicate how SAIF was authorized to recover the overpayment. Consequently, we modify the Referee's offset authorization to so indicate.

While ORS 656.268(13) authorizes only adjustments in compensation due to overpayment at the time of closure by Determination Order or Notice of Closure, we may approve an offset against future compensation under circumstances not involving a Determination Order or Notice of Closure. SAIF v. Zurich, 94 Or App 661 (1989); Steven F. Sutphin, 44 Van Natta 2126 (1992); Steve E. Maywood, 44 Van Natta 1199 (1992). Therefore, despite our determination here that claimant's claim was prematurely closed, we find that we have authority to approve an offset. However, these overpaid temporary disability benefits are recoverable only against future permanent disability awards resulting from the claim wherein the overpayment occurred. Robert E. Kubala, 43 Van Natta 1495 (1991); Patricia A. Landers, 44 Van Natta 1543 (1992).

Accordingly, SAIF is authorized here to recover its \$9,259.32 overpayment against claimant's future permanent disability awards, if any, resulting from this claim.

Attorney Fee

Inasmuch as our finding of premature closure will result in increased temporary disability benefits, we conclude that claimant's counsel is entitled to an attorney fee payable from this increased compensation. ORS 656.386(2); OAR 438-15-055; Doris S. Klager, 44 Van Natta 982 (1992). Consequently, we award claimant's counsel 25 percent of any increased temporary disability benefits created by this order. However, the total out-of-compensation attorney fees granted by the Referee's order and this order shall not exceed \$3,800. This award is in addition to the assessed fees awarded by the Referee (totalling \$2,550) under the portions of the order affirmed by this order.

ORDER

The Referee's order dated January 21, 1992, as reconsidered February 13, 1992, is reversed in part, vacated in part, modified in part and affirmed in part. That portion of the Referee's order that found claimant's claim was not prematurely closed is reversed. That portion of the Referee's order that upheld the SAIF Corporation's denial of claimant's aggravation claim is vacated. The August 5, 1991 Determination Order is set aside as premature. Claimant's claim is remanded to SAIF for further processing according to law. SAIF is authorized to recover its \$9,259.32 overpayment against claimant's future permanent disability awards payable during the life of this claim. Claimant's attorney is awarded 25 percent of any increased compensation created by this order, payable directly to claimant's attorney. However, the total "out-of-compensation" fees granted by this order and the Referee's order shall not exceed \$3,800. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
JIMMIE H. PREWITT, Claimant
WCB Case No. 91-16750
ORDER ON REVIEW
Pozzi, et al., Claimant Attorneys
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Brazeau.

Claimant requests review of those portions of Referee Quillinan's order that: (1) affirmed the Order on Reconsideration award of 24 percent (76.8 degrees) unscheduled permanent disability for a bilateral shoulder condition and 5 percent (9.6 degrees) scheduled permanent disability for the loss of use or function of the right arm; and (2) declined to assess a penalty and related attorney fee for the SAIF Corporation's allegedly unreasonable refusal to pay his scheduled permanent disability award at the rate of \$305 per degree. On review, the issues are extent of scheduled and unscheduled permanent disability, rate of scheduled permanent disability, penalties and attorney fees. We modify in part, reverse in part, and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

Claimant contends that neither the Referee nor the Board has jurisdiction to consider SAIF's challenge to the Order on Reconsideration because SAIF did not, and could not, request reconsideration of its Notice of Closure. We disagree.

Claimant cites to ORS 656.268(4)(e) as supporting authority. However, that provision merely states that a worker who objects to a notice of closure must first request reconsideration by the Department of Insurance and Finance. We find no similar requirement for an insurer. Indeed, inasmuch as the Notice of Closure was issued by the insurer, it would be inconsistent to require the insurer to request reconsideration of its own Notice of Closure. In reaching this conclusion, we wish to emphasize that an insurer is not entitled to seek a hearing directly from its Notice of Closure. Rather, as with claimant, it must await issuance of an Order on Reconsideration before the Hearings Division secures jurisdiction over a permanent disability dispute.

Thus, once reconsideration of the Notice of Closure is requested by the worker and completed by the Department, ORS 656.268(6)(b) permits any party objecting to the reconsideration order to request a hearing under ORS 656.283. Here, claimant timely requested a hearing on the Order on Reconsideration. Accordingly, the Referee properly had jurisdiction to review the extent of claimant's permanent disability.

SAIF did not specifically cross-request a hearing to challenge the Order on Reconsideration. However, the parties agree on Board review that SAIF reserved a challenge to the adaptability value found by the Department until claimant's post-hearing deposition. (See Resp. Br. at 2; Reply Br.). After the deposition, SAIF raised its challenge to the adaptability value. At that time, claimant could have requested a continuance to cure any surprise or prejudice which may have resulted from SAIF's challenge. See OAR 438-06-031. Claimant made no showing of prejudice and did not request a continuance. Therefore, the Referee properly considered SAIF's challenge to the Order on Reconsideration. See William K. Porter, 44 Van Natta 937, 944 (1992).

Extent of Permanent Disability

Because claimant was found medically stationary after July 1, 1990, and his claim was closed by Notice of Closure on May 28, 1991, we apply the standards for rating permanent disability in WCD Admin. Order 2-1991 (effective April 1, 1991). See OAR 436-35-003(2).

Considering the Order on Reconsideration award, claimant has been awarded a total of 64 percent for unscheduled permanent disability for the bilateral shoulder condition and 5 percent scheduled permanent disability for the loss of use or function of the right arm. Claimant seeks additional awards of scheduled and unscheduled permanent disability. We modify.

Scheduled Permanent Disability: Right Arm

Claimant was awarded 5 percent scheduled permanent disability benefits for the right arm because he is unable to repetitively use the arm due to a chronic condition. The parties do not challenge this award; however, claimant seeks additional awards based on loss of strength and a humeral head replacement surgery.

Regarding loss of strength, claimant seeks an award based on a rupture of the biceps tendon. See former OAR 436-35-110(2). For support, he cites to an October 17, 1991 questionnaire by Dr. Whitney, the attending physician, and the April 9, 1991 independent medical examination (IME) report by Drs. Bald and Barth, to which Dr. Whitney concurred. (See Exs. 5, 6, 11-A-4).

Under the standards, loss of strength must be determined on the basis of medical evidence which measures the loss using a 0 to 5 grading system and identifies the spinal nerve root, peripheral nerve, or plexus which is responsible for the loss. See former OAR 436-35-007(14). Here, the IME report notes that claimant has "clinical loss of the normal superior biceps muscle mass consistent with bilateral biceps tendon ruptures," (Ex. 5-5), but the report does not measure the loss on a 0 to 5 grading system. Therefore, the loss is not rateable under the standards. See ORS 656.295(5).

Dr. Whitney measured the following losses of strength due to disruption of musculotendonous units: deltoid, 3/5; subscapular, 3/5; supraspinatus, 3/5; and infraspinatus, 3/5. (Ex. 11-A-4). We agree with the Department and the Referee, however, that those losses address musculotendonous units in the right shoulder area, not the arm itself. See former OAR 436-35-350(3). Therefore, the losses are properly rated as unscheduled permanent disability. See ORS 656.214(5); former OAR 436-35-270(1).

Dr. Whitney also noted that claimant underwent humeral head replacement surgery. (Ex. 11-A-8). This finding is supported by the IME report, (see Ex. 5-2), and is not controverted. Under the standards, the surgery is rated at 15 percent impairment of the arm. See former OAR 436-35-110(4)(k). Combining 15 percent with the 5 percent chronic condition impairment yields a total of 19 percent scheduled permanent disability benefits for the right arm. We modify accordingly.

Scheduled Permanent Disability: Left Arm

Claimant was awarded no permanent disability for the left arm. He seeks awards for the left arm based on loss of strength and a chronic condition limiting repetitive use of the arm.

For loss of strength findings, claimant again relies on the IME report and Dr. Whitney's questionnaire. (Exs. 5-5, 11-A-6). As we stated above, the IME report does not provide findings which are rateable under the standards. Dr. Whitney measured the following losses of strength due to disruption of musculotendonous units: subscapular, 4/5; and supraspinatus, 4/5. (Ex. 11-A-6). However, those losses address musculotendonous units in the left shoulder, not the arm, and must be rated as unscheduled permanent disability. See former OAR 436-35-350(3), 436-35-270(1).

Dr. Whitney reported that claimant has a chronic condition which renders him unable to repetitively use the left arm. (Ex. 11-A-17). The medical record as a whole supports a finding that the disruption of the musculotendonous units involving the left shoulder prevents claimant from repetitively using the left arm. There is no contrary evidence. Therefore, under the standards, claimant is entitled to 5 percent scheduled permanent disability for the left arm. See former OAR 436-35-010(6). We modify accordingly.

Unscheduled Permanent Disability: Shoulders

Claimant has been awarded 64 percent unscheduled permanent disability. He seeks an additional award, contending that the adaptability factor should be valued at 3, rather than 1.

Before addressing claimant's contention, we first rate the impairment factor. As we stated above, Dr. Whitney measured the following losses of strength in the shoulder area: subscapular, 4/5; and supraspinatus, 4/5. (Ex. 11-A-6). The loss of subscapular strength is computed by converting 4/5 to 20 percent and multiplying that value by 3 percent, the total percentage of impairment allowed for subscapular loss. See former OAR 436-35-007(14), 436-35-350(3). The product is then rounded up to 1 percent. See former OAR 436-35-007(11).

The loss of supraspinatus strength is computed by converting 4/5 to 20 percent and multiplying that value by 9 percent, the total percentage of impairment allowed for supraspinatus loss. See former OAR 436-35-007(14), 436-35-350(3). The product is then rounded up to 2 percent. See former OAR 436-35-007(11). This value is combined with the 1 percent subscapular loss for a total of 3 percent loss of left shoulder strength.

The aforementioned total is then combined with the following uncontested values for unscheduled impairment: 30 percent for right shoulder total arthroplasty; 18 percent for loss of right shoulder strength; 10 percent for loss of range of right shoulder motion; 9 percent for loss of range of left shoulder motion; and 5 percent for right shoulder acromioplasty. (See Ex. 12-3, -4). The total impairment value is 57 percent.

Regarding the adaptability factor, the Referee rated the factor at 1 based on the finding that claimant had returned to his job at injury as a full-time log truck driver for about three months prior to the Order on Reconsideration. On review, claimant contends that the adaptability value should be 3 because he has effectively modified his job to lighter work.

We have previously held that the adaptability factor is evaluated based on the worker's work status at the time of determination, *i.e.*, the mailing date of the Determination Order or Notice of Closure. See former OAR 436-35-005(12), 436-35-310(1); Heather I. Smith, 44 Van Natta 2207 (1992); Vickie M. Libel, 44 Van Natta 294, on recon 44 Van Natta 413 (1992).

On the mailing date of the May 28, 1991 Notice of Closure, claimant had not yet returned to work. (See Exs. 8, 14-4). On that date, he had a release for light work. (See Exs. 5-6, 6). It is undisputed that claimant's job at injury was medium work. Therefore, using the table in former OAR 436-35-310(3), we find the adaptability value to be 3.

We now assemble the factors to compute claimant's unscheduled permanent disability. It is undisputed that the value for claimant's age and education is 6. Multiplying that value by the adaptability value yields a product of 18, which is added to the 57 percent impairment value for a total unscheduled permanent disability award of 75 percent. See former OAR 436-35-280. Subtracting claimant's prior award of 40 percent unscheduled permanent disability, we modify the Order on Reconsideration to award 35 percent unscheduled permanent disability.

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).

Penalties and Attorney Fees

Under the Herron decision, SAIF's action was not unreasonable. No penalty and attorney fee may be assessed.

ORDER

The Referee's order dated April 8, 1992 is modified in part, reversed in part and affirmed in part. In addition to the Order on Reconsideration award of 24 percent (76.8 degrees) unscheduled permanent disability and 5 percent (9.6 degrees) scheduled permanent disability for the loss of use or function of the right arm, claimant is awarded 11 percent (35.2 degrees) unscheduled permanent disability, 14 percent (26.88 degrees) scheduled permanent disability for the loss of use or function of the right arm, and 5 percent (9.6 degrees) scheduled permanent disability for the loss of use or function of the left arm, giving claimant a total award of 35 percent (112 degrees) unscheduled permanent disability, 19 percent (36.48 degrees) scheduled permanent disability for the loss of use or function of the right arm, and 5 percent (9.6 degrees) scheduled permanent disability for the loss of use or function of the left arm. Claimant's attorney is awarded an out-of-compensation attorney fee in the amount of 25 percent of the increased compensation created by this order, not to exceed \$3,800, payable directly to claimant's attorney. Those portions of the order that directed SAIF to pay claimant's scheduled permanent disability award at the rate of \$305 per degree and awarded an out-of-compensation attorney fee payable from that increased compensation are reversed. The remainder of the order is affirmed.

December 30, 1992

Cite as 44 Van Natta 2549 (1992)

In the Matter of the Compensation of
RHONDA E. PURDY, Claimant
WCB Case No. 90-00610
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
John Pitcher, Defense Attorney

Reviewed by Board Members Hooton and Kinsley.

Claimant requests review of Referee McWilliam's order that dismissed claimant's request for hearing on a September 12, 1990 Determination Order. On review, the issue is the propriety of the Referee's dismissal. We reverse.

FINDINGS OF FACT

Claimant is 40 years old and has a high school education. In June 1984, she compensably injured her back while performing heavy work for the employer. Following a period of conservative treatment, her claim was closed in December 1985 with an award of benefits for periods of temporary disability and 10 percent unscheduled permanent partial disability.

On February 20, 1986, claimant began treating with Dr. Radmore, a psychiatrist, for an adjustment and somatization disorder. On March 16, 1989, the Board issued an Order on Review, which concluded that claimant's psychiatric condition was compensably related to her work-related back injury and that her claim had been prematurely closed.

In January 1989, claimant experienced a temporary exacerbation of her back condition. On July 1, 1989, she was examined by the Western Medical Consultants, who reported that her back had returned to medically stationary status and that she retained 80 degrees of forward flexion and 28 degrees of left lateral flexion of the lumbar spine, and 50 degrees of bilateral rotation, 33 degrees of right lateral flexion and 31 degrees left lateral flexion of the cervical spine.

Claimant's claim was reclosed by an August 23, 1989 Determination Order, which found her to be medically stationary as of July 1, 1989 and awarded benefits for temporary disability through that date. In lieu of her prior 10 percent unscheduled permanent disability award, claimant's total award was found to be 11 percent.

In November 1989, claimant enrolled in an Authorized Training Program (ATP). During her training, claimant received psychological treatment from Dr. Forester, who declared her medically stationary with regards to her psychological condition in August 1990.

Following completion of the ATP, the claim was reclosed by a September 12, 1990 Determination Order, which awarded benefits for temporary disability from November 20, 1989 through August 24, 1990, and reaffirmed the permanent partial disability award and medically stationary date determined in the earlier order.

Claimant is suffering from Class 1 Residual Depressive Reaction in the minimal range. She has intermittent periods of depression secondary to pain and physical limitations. She is currently performing heavy work as an uncertified veterinary technician.

CONCLUSIONS OF LAW AND REASONING

Claimant filed a request for hearing, asserting, *inter alia*, that a September 12, 1990 Determination Order, which found her to be medically stationary on July 1, 1989, had prematurely closed her claim. The Referee reviewed the evidence and found that claimant actually became medically stationary on August 9, 1990. Based on that new date, however, the Referee concluded that claimant was first required to seek reconsideration of the Determination Order with the Department pursuant to ORS 656.268(5) and dismissed the request for hearing.

Traditionally, a worker who objected to a Determination Order could request a hearing with the Board under ORS 656.283. The legislature, however, significantly modified the process of review of Determination Orders during its 1990 Special Session. Under the current version of ORS 656.268(5), an objecting party must first request reconsideration with the Department. Upon receipt of the request, the Department conducts a reconsideration proceeding and issues an order. Only after the Department has issued a reconsideration order may a party request a hearing under ORS 656.283. ORS 656.268(6)(b); Lorna D. Hilderbrand, 43 Van Natta 2721 (1991).

The question presented concerns the applicability of this new mandatory reconsideration procedure. Oregon Laws 1990 (Special Session), chapter 2, section 54(3) provides:

"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.)

The employer favors a literal application of that provision and argues that the amendments to ORS 656.268 apply to any claim ultimately determined to be medically stationary after July 1, 1990. Claimant responds that such an application would produce an absurd result and argues that application of the mandatory reconsideration procedure is controlled by the medically stationary date determined at claim-closure. We agree with claimant and reverse.

In construing a legislative enactment, our analysis begins with the language itself. See ORS 174.020. In determining the meaning of the words used, we may properly consider the legislative purpose and construe the language to reasonably accomplish that purpose. Mallon v. Emp. Div., 41 Or App 479 (1979). We may also presume that the legislature did not intend absurd or unjust results that a literal application of the language would seem to require. As noted in Fish v. Bishop, 176 Or 210 (1945):

"All laws should receive a sensible construction. General terms should not be so limited in their application to lead to injustice, oppression, or an absurd consequence. It will always therefore be presumed that the Legislature intended exceptions to its language which would avoid results of this character. The reason of the law in such cases should prevail over its letter."

In this case, a literal interpretation of section 54(3) would unnecessarily increase litigation and possibly leave an objecting party without a legal remedy. For example, if a Determination Order finds a worker medically stationary prior to July 1, 1990, as in this case, the mandatory reconsideration procedures do not apply and, accordingly, the worker must request a hearing with the Board. If the worker raises the issue of premature closure, however, and the Referee concludes that claimant was not medically stationary before July 1, 1990, a strict construction of section 54(3) would require the Referee to dismiss the request for hearing, simply because the worker had successfully established entitlement to

the relief sought. The worker would then be required to seek a Reconsideration Order with the Department, assuming that the Determination Order had not yet become final as a matter of law. If the Department declined to set aside the Determination Order, the worker could then return to the Hearings Division to have the Determination Order set aside consistent with the findings of the Referee in the prior hearing.

Rather than create such a confused and unnecessarily complex process for evaluating disability awards, we conclude that the phrase "all claims which become medically stationary after July 1, 1990," refers to claims initially determined to be medically stationary after that date upon closure, so that the application of the 1990 amendments to ORS 656.268 is controlled by the medically stationary date contained in the Determination Order or Notice of Closure. That interpretation, in our opinion, not only avoids the undesirable results discussed above, but is also consistent with the legislature's stated policy favoring a fair administrative system for the delivery of benefits to workers "that reduces litigation * * * to the greatest extent possible." ORS 656.012(2)(b).

Applying that interpretation to the facts of this case, the amendments to ORS 656.268 do not apply, because the September 1990 Determination Order found claimant to be medically stationary on July 1, 1989. Accordingly, claimant is entitled to a hearing, and the Referee was without authority to dismiss claimant's hearing request with prejudice. Finding the record sufficiently developed, we proceed with our review.

Premature Closure

A claim for compensation shall not be closed if the worker's condition has not become medically stationary. ORS 656.268(1). A worker is considered medically stationary when "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). Claimant bears the burden of proving that she was not medically stationary at the date of closure. Berliner v. Weyerhaeuser, 54 Or App 624 (1981).

In this case, there is no dispute that claimant's low back condition became medically stationary by July 1, 1989. Nonetheless, the extent of an injured worker's disability cannot be determined until she is medically stationary from all conditions resulting from the compensable injury. Kociemba v. SAIF, 63 Or App 557 (1987). Accordingly, we must determine when claimant's psychiatric condition attained medically stationary status.

The resolution of the medically stationary date is primarily a medical question based on competent medical evidence. Harmon v. SAIF, 54 Or App 121 (1981). In this case, two medical experts opinions were submitted in this matter. Dr. Forester, a psychologist who treated claimant during her ATP, opined that claimant's condition became medically stationary in August 1990. In contrast, Dr. Paravaresh, who has examined claimant on three occasions, opined that claimant does not have a diagnosable psychiatric disorder and was, therefore, medically stationary when he first examined her in 1986.

When there is a dispute between medical experts, we give greater weight to those opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1990). We only find the opinion of Dr. Forester meets both criteria and, accordingly, give it the most weight. We are not persuaded by the contrary opinion of Dr. Paravaresh, who bases his opinion on his conclusion that claimant does not have a diagnosable psychiatric disorder. That conclusion conflicts with the law of the case and, as a legal matter, is incorrect. See Kuhn v. SAIF, 73 Or App 768 (1985).

Based on Dr. Forester's opinion, we find that claimant's psychological condition became medically stationary in August 1990. Accordingly, claimant was not medically stationary at the time her claim was first closed by the August 23, 1989 Determination Order, which is hereby set aside as premature. As a result of that conclusion, claimant is entitled to benefits for temporary disability, less time worked, from July 1, 1989, the prior medically stationary date, through November 19, 1989, the date she enrolled in the ATP. We further note, however, that claimant was medically stationary when her claim was reclosed by the September 12, 1990 Determination Order upon the completion of the ATP, and we therefore conclude that claimant has failed to establish that her claim was prematurely closed at that time. Berliner v. Weyerhaeuser, *supra*. We proceed to rate the extent of her permanent disability.

Extent of Unscheduled Disability

For purposes of determining injury-related permanent partial disability, ORS 656.295(5) require application of the standards 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 claim was closed by Determination Order on September 12, 1990, we apply the standards set forth in WCD Administrative Order 6-1988.

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

Age and Education

The appropriate value for claimant's age of 40 years is 1. Former OAR 436-35-290.

The appropriate value for claimant's 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 a veterinarian assistant (DOT # 410.664-010). Therefore, the appropriate value for skills is 3. Former OAR 436-35-300(4).

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

Here, claimant has not demonstrated competence in a specific vocational pursuit. Therefore, the appropriate training value 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 [see former OAR 436-35-270(3)(d)] is determined from a matrix of values at former OAR 436-35-310(3)(a). That matrix compares the physical capacity of the claimant's usual and customary work with the physical capacity required by the modified work. This is true even though claimant may have the physical capacity to do heavier work than is required by the modified employment. Physical capacities are not defined by the "standards" generally. We utilize those definitions contained in former OAR 436-35-310(4)(a)-(d).

In this case, claimant's usual and customary work required the physical capacity to do heavy work. Claimant's modified work required a heavy physical capacity. Therefore, the appropriate adaptability value is 1. Former OAR 436-35-310(3)(a).

Impairment

The criteria to be used in rating the impairment resulting from a permanent state of mental disorder are found in former OAR 436-35-400. Mental disorders are divided into personality disorders, psychoneuroses and psychosis conditions. Psychoneuroses are, in turn, subdivided into three classes as defined by the severity and duration of the symptoms.

In this case, the medical evidence establishes that, as a result of her compensable injury, claimant suffers from a Class 1 Residual Depressive Reaction in the minimal range. Accordingly, claimant's impairment is properly analyzed under former OAR 436-35-400(4)(a)(B). Under that rule, we award a value of 5 percent impairment for her resultant intermittent periods of depression secondary to pain and physical limitations.

As a result of the compensable injury, claimant also suffers from restricted ranges of motion in the lumbar and cervical spine. For 80 degrees of forward flexion of the lumbar spine, claimant is entitled to an award of 1 percent. Former OAR 436-35-360(6). For 28 degrees of left lateral flexion, claimant is entitled to an award of .5 percent. Former OAR 436-35-360(8). For 50 degrees of left and right rotation in the cervical spine, claimant is entitled to a total award of 3 percent. Former OAR 436-35-360(5). Claimant is also entitled to awards of 1 percent impairment each for 33 degrees of right lateral flexion and 31 degrees left lateral flexion of the cervical spine. Former OAR 436-35-360(4).

The values for lost range of motion of both parts of the spine are added (not combined), for a total award of 1.5 percent in the lumbar spine, and 5 percent in the cervical spine. Former OAR 436-35-360(10). Those two values are combined, not added, for a final rating of 5.5 percent. Former OAR 436-35-360(11).

Computation of Unscheduled Permanent Disability

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. When claimant's age value 1 is added to his education value 4, the sum is 5. When that value is multiplied by claimant's adaptability value 1, the product is 5. When that value is added to claimant's total impairment value 10.5, the result is 15.5 percent unscheduled permanent partial disability. Former OAR 436-35-280(7). That disability figure is rounded to the next higher whole percentage. Former OAR 436-35-280(7). Claimant's permanent disability under the standards is, therefore, 16 percent.

ORDER

The Referee's order dated October 3, 1991 is reversed. The August 23, 1989 Determination Order is set aside as premature. Claimant is awarded benefits for temporary disability, less time worked, from July 2, 1989 through November 19, 1989. The September 12, 1990 Determination Order is affirmed, except that claimant's unscheduled permanent disability award is modified as follows. Claimant's total award of unscheduled permanent disability is 16 percent (51.2 degrees). Claimant is awarded additional unscheduled permanent disability in an amount sufficient to meet this 16 percent (51.2 degrees) total. Claimant's attorney is awarded an attorney fee equal to 25 percent of the increased temporary and permanent disability compensation made payable by this order, not to exceed \$3,800.

December 30, 1992

Cite as 44 Van Natta 2553 (1992)

In the Matter of the Compensation of
ADELAIDA ROBLES-CASTANEDA, Claimant
WCB Case No. 91-13066
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Julene Quinn (Saif), Defense Attorney

Reviewed by Board Members Kinsley, Brazeau and Hooton.

Claimant requests review of Referee Mills' order which increased her unscheduled permanent disability award for a left shoulder injury from 38 percent (121.60 degrees), as awarded by an Order on Reconsideration, to 43 percent (137.6 degrees). In its respondent's brief, the SAIF Corporation seeks reduction of claimant's permanent disability award. On review, the issue is extent of unscheduled permanent partial disability. We modify.

FINDINGS OF FACT

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

At hearing, the parties stipulated that claimant is 59 years old, she has no formal education, and her job at the time of injury had a medium strength rating.

CONCLUSIONS OF LAW AND OPINION

In determining the extent of claimant's permanent disability, the Referee applied the "standards" in effect on the date of claimant's June 12, 1991 Determination Order, pursuant to ORS 656.283(7). We agree that the applicable standards are those which became effective April 1, 1991, WCD Admin. Order 2-1991, and apply those same standards here.

Under those "standards," the determination of unscheduled permanent partial disability is made by ascertaining the appropriate values assigned to claimant's age, education adaptability, and impairment. Once established, the values for age and education are added and the sum is multiplied by the appropriate value for adaptability. The product of those two figures is then added to the appropriate value for impairment to yield the percentage of unscheduled permanent partial disability. Former 436-35-280. Following this formula, we proceed to determine the appropriate values necessary to compute claimant's award.

Age and Education

Pursuant to their stipulation, the parties do not dispute the values assigned by the Referee to claimant's age (1), formal education (1), and lack of training (1). The parties do, however, disagree with respect to the Dictionary of Occupational Titles (DOT) Code classification and the highest specific vocational pursuit (SVP) level assigned by the Referee.

With regard to the DOT Code, the Referee determined that claimant was a nursery worker (DOT Code 405.687-014) with an SVP level of 2. We agree.

On review, SAIF contends that the appropriate job category is that of a garden worker (DOT Code 406.684-018) with an SVP level of 4. In support of its contention, SAIF points to the testimony of Mr. Thompson, claimant's foreman.

Mr. Thompson testified that the description of the garden worker classification was consistent with claimant's duties. (Tr. 21-22). However, we do not find Mr. Thompson's opinion dispositive. The "406" classification is limited to gardening and groundskeeping occupations and includes jobs which involve the manicuring and care of a parcel or tract of land. On the other hand, the "405" classification is limited to nursery occupations and includes jobs which involve propagating and raising plants and other nursery products. The uncontroverted evidence at hearing indicates that claimant works in a nursery where she raises plants and other nursery products and does not provide groundskeeping services. Consequently, the appropriate DOT code must come from the "405" classification.

Moreover, given claimant's testimony regarding the nature of her employment duties and the limited training time involved in learning those duties, the Referee appropriately found her job to fall within DOT Code 405.687-014 with an SVP level of 2, giving her a skills value of 4. Accordingly, adopt that portion of the Referee's order.

Adaptability

Turning to claimant's adaptability value, the Referee found that, pursuant to the parties' stipulation at hearing, claimant's prior strength level at the time of her injury was medium. We agree.

On review, however, claimant now argues that the Referee should have rejected the parties' stipulation and applied the strength category mandated by the nursery worker classification (DOT Code 405.687-014). We reject claimant's argument.

We have previously stated that it is our policy to encourage parties to resolve disputed issues and to approve agreements reached by the parties, unless it appears that the agreement was obtained by a party's unfair advantage over another. Dana W. Wood, 44 Van Natta 2241 (1992). Here, claimant does not argue that SAIF unfairly obtained the stipulation nor do we find any evidence to support such

an argument. Therefore, based on the parties' agreement at hearing, claimant's strength level prior to injury was within the medium category.

The Referee also found, based on the August 28, 1991 report by Dr. Bald, claimant's attending physician (Ex. 26), that claimant had returned to modified work with a lifting limitation of 10 pounds. Therefore, the Referee determined that claimant's residual strength level after injury was within the sedentary category. See former OAR 436-35-270(3)(h). We agree.

On review, SAIF argues that, because the language of Dr. Bald's August 28, 1991 report is in conflict with his previous lifting restriction of 15 to 20 pounds, the report was a "mistake" and Dr. Bald's intent was to continue claimant's previous restrictions and not to reduce her lifting restriction to 10 pounds. We do not find SAIF's argument persuasive. While Dr. Bald did state that claimant was to "continue under her previous restrictions," we interpret that statement to refer not to the previous lifting limitation of 15 to 20 pounds, but to the restriction that claimant avoid repetitive and overhead use of her left arm. (Ex. 13). We also note that subsequent to the 15 to 20 pound lifting limitation, claimant's condition worsened. (Ex. 18a).

Consequently, on this record we find that claimant's residual strength level after injury was within the sedentary category, and therefore, that claimant's appropriate adaptability value is 5. Former OAR 436-35-310(3).. Accordingly, we also adopt that portion of the Referee's order.

Impairment

With regard to claimant's loss of range of motion, claimant does not dispute the Referee's impairment rating and SAIF does not dispute the values assigned by the Referee for loss of abduction (4) or for loss of external rotation (1.5). However, SAIF argues that claimant should have received a value of 0, instead of 2, for loss of flexion. We agree.

Dr. Bald measured claimant's loss of forward flexion on the left at 150 degrees. (Ex. 13). Consequently, pursuant to former OAR 436-35-330(1), claimant is entitled to a value of 0. Therefore, adding these impairment values together, claimant's total impairment is 5.5 percent, rounded up to 6 percent. Former OAR 436-35-330(17).

Having determined each value necessary to compute claimant's permanent disability under the "standards," we proceed to that calculation. Adding the values assigned for claimant's age (1) to those assigned to her education (6), claimant is entitled to a combined age and education value of 7. Multiplying that value by claimant's adaptability value (5), the product is 35. When that value is added to claimant's impairment value (6) the result is a total unscheduled permanent disability award of 41 percent. See former OAR 436-35-280(7). Accordingly, we modify the Referee's order.

ORDER

The Referee's order dated January 8, 1992 is modified. In lieu of the Referee's unscheduled permanent disability award, and in addition to the Order on Reconsideration award of 38 percent (121.60 degrees) unscheduled permanent disability, claimant is awarded 3 percent (9.60 degrees) unscheduled permanent disability, giving her a total unscheduled permanent disability award of 41 percent (131.2 degrees). Claimant's attorney fee award is adjusted accordingly.

In the Matter of the Compensation of
LAUREN G. SEMLER, Claimant
Own Motion No. 92-0696M
OWN MOTION ORDER
Coons, et al., Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable low back injury. Claimant's aggravation rights expired on May 5, 1991. SAIF recommends that we authorize the payment of temporary disability compensation, but notes that is is uncertain whether claimant was in the work force at the time of his worsening. SAIF also requests authorization for reimbursement from the Reopened Claims Reserve.

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). SAIF has submitted a copy of its November 19, 1992 investigation report in which claimant stated that he plays guitar, part-time, in various bands and earns approximately \$400 a month. In addition, Mr. Jim Smith submitted a letter stating that he has played in bands with claimant for seven years. Therefore, 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 September 11, 1992, the date he was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-12-055.

SAIF also requests the Board to authorize reimbursement from the Reopened Claims Reserve pursuant to ORS 656.625(b). The Court of Appeals has held that the Board lacks the authority to grant or deny reimbursement from the Reserve. *See SAIF v. Holmstrom*, 113 Or App 242 (1992). Accordingly, we are unable to grant SAIF's request.

IT IS SO ORDERED.

December 30, 1992

Cite as 44 Van Natta 2556 (1992)

In the Matter of the Compensation of
JAMES E. SMITH, Claimant
WCB Case No. 92-00609
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
H. Thomas Andersen (Saif), Defense Attorney

Reviewed by Board Members Gunn and Westerband.

Claimant requests review of Referee Brazeau's order that affirmed on Order on Reconsideration which did not award permanent disability benefits for a right index finger injury. On review, the issue is extent of scheduled permanent disability.

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

Claimant argues that he is entitled to an award of 5 percent scheduled disability for a "chronic condition" limiting the use of his right index finger/hand. He argues that, contrary to the Referee's conclusion, Dr. Dreyer's closing report is sufficient to support a finding of medical evidence of objective impairment. However, even assuming that Dr. Dreyer's report constitutes objective evidence of impairment, that impairment is not ratable under the applicable standards.

Claimant was medically stationary on October 21, 1991 and his claim was closed on November 19, 1991. Therefore, WCD Admin. Order 2-1991 (effective April 1, 1991) applies in rating his disability. Former OAR 436-35-003(1). Only claimant's right index finger was injured, and he has no impairment other than a possible chronic condition.

The list of the body parts which may be awarded an impairment for chronic condition includes: "foot/ankle, knee, leg, hand/wrist, elbow, and arm." Former OAR 436-35-010(6). Therefore, in order to be eligible for a chronic condition impairment, the medical evidence would have to show a chronic condition in claimant's hand/wrist rather than only his right index finger. Dr. Dreyer's closing report does not support such a finding.

Furthermore, because claimant injured only one finger, even if he had a ratable impairment in that finger, it could not be converted into a hand value and thus qualify for a chronic condition impairment. The applicable standards do not provide for conversion of thumb/finger impairment values into a hand value unless there is a loss of use of two or more digits. Former OAR 436-35-070(1).

ORDER

The Referee's order dated April 13, 1992 is affirmed.

December 30, 1992

Cite as 44 Van Natta 2557 (1992)

In the Matter of the Compensation of
RICHARD D. WALKER, Claimant
WCB Case No. 91-10954
ORDER ON REVIEW

Richard F. McGinty, Claimant Attorney
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Gunn and Brazeau.

Claimant requests review of that portion of Referee Poland's order that upheld the SAIF Corporation's denial of claimant's current low back condition. In his brief, claimant argues that SAIF's denial is invalid as a prospective denial. On review, the issues are compensability, responsibility, and validity of the denial.

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

On April 25, 1989, claimant sustained a compensable injury to his low back. SAIF accepted this injury as a lumbosacral strain. (Ex. 54A). On December 11, 1990, the Board approved a Claim Disposition Agreement (CDA) between claimant and SAIF regarding this injury. (Ex. 96A). In exchange for \$12,000, claimant gave up, among other things, his aggravation rights on the accepted low back injury claim with SAIF. (Ex. 96A-9). Claimant retained his right to compensable medical services related to that claim. Thus, if SAIF is found responsible for claimant's current condition, its responsibility extends only to compensable medical services.

Subsequent to the December 11, 1990 CDA, the employer became self-insured. On April 5, 1991, claimant was hospitalized for low back pain following work activities as a firefighter that day. He filed a Workers' Compensation claim. On June 28, 1991, the employer denied that claim, contending that claimant's condition was an aggravation of his prior accepted injury with SAIF. (Ex. 109-1). Subsequently, claimant and the employer entered into a Disputed Claim Settlement (DCS), agreeing that the June 28, 1991 denial would be affirmed in exchange for \$2,000. (Tr. 4).

Citing Delta/McLean Trucking v. Wyncoop, 106 Or App 319 (1991), claimant argues that SAIF remains responsible for his current low back condition because there was no worsening of his underlying condition as a consequence of the April 5, 1991 work activities. However, Wyncoop is not determinative because it applies the law in effect prior to the 1990 amendments to the Workers' Compensation Act. Here, because claimant requested a hearing after May 1, 1990 and a hearing was convened after July 1, 1990, his claim is properly analyzed under the 1990 revisions to the Workers' Compensation Act. See Ida M. Walker, 43 Van Natta 1402 (1991).

We have interpreted Section 49(1) of the amended law, codified at 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); Ronald L. Rushton, 44 Van Natta 124 (1992). Thus, in this case, SAIF, as the last insured against whom claimant had an accepted low back injury, remains presumptively responsible. In order to avoid responsibility, SAIF has the burden of establishing that claimant sustained a new compensable injury involving the same condition while working for the employer in its self-insured capacity.

Dr. Poulson, attending physician, opined that the April 5, 1991 work incident "is new accident and is the major cause of his present problems. . . ." (Ex. 107). Poulson's opinion is un rebutted. Furthermore, Dr. Poulson's treatment history with claimant for his low back pain extends from before the April 1989 accepted injury through the hearing date. Therefore, he is in the best position to determine whether claimant sustained a new injury.

The Board generally gives greater weight to the conclusions of a treating physician; however, it will not so defer when there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we defer to the opinion of Dr. Poulson and conclude that claimant sustained a new injury on April 5, 1991 while the employer was self-insured. Thus, but for the DCS, responsibility would have shifted to the employer in its self-insured capacity. See Jack Spinks, 43 Van Natta 1351 (1991), aff'd mem Spinks v. Mosley and Sons, 112 Or App 661 (1992) (claimant not entitled to further compensation against the responsible carrier because he settled his claim with that carrier pursuant to a DCS).

At the hearing, claimant argued that he was entitled to penalties and attorney fees because SAIF's August 26, 1991 denial was untimely. The Referee found no amounts then due upon which to base penalties and attorney fees since SAIF had timely paid interim compensation until it denied the claim. On review, claimant does not challenge that finding. However, in his brief, he argues that because there were no amounts then due when SAIF denied the claim, the denial should be set aside as prospective. 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). In any event, SAIF's denial of claimant's current condition was not a prospective denial. It was neither an improper denial of an accepted condition nor an impermissible denial of future treatment for an accepted condition. Roller v. Weyerhaeuser Co., 67 Or App 583, recon 680 Or App 743, rev den 297 Or 601 (1984); Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989).

ORDER

The Referee's order dated April 2, 1992 is affirmed.

In the Matter of the Compensation of
SUSAN V. ALLEY, Claimant
WCB Case No. 91-16386
ORDER ON REVIEW
John McCourt, Claimant Attorney
Mitchell, et al., Defense Attorneys

Reviewed by Board Members Moller and Brazeau.

Claimant requests review of Referee Mills' order that upheld the self-insured employer's denial of claimant's disc protrusion condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact except for the last paragraph.

CONCLUSIONS OF LAW AND OPINION

ORS 656.005(7)(a)(A) 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." Under this statute, if a condition or need for treatment is caused by the compensable injury, then the major contributing test applies. Albany General Hospital v. Gasperino, 113 Or App 411 (1992). However, if a condition or need for treatment is caused by the industrial injury, then the material contributing test applies. Id.

The Referee analyzed compensability under ORS 656.005(7)(a)(A), finding that claimant was required to prove that her compensable 1982 injury was the major contributing cause of her C4-5 disc protrusion. We agree and adopt his "Conclusions and Opinion." However, even if claimant need only prove that the 1982 injury was a material contributing cause of her disc protrusion, she still fails to carry her burden of proof.

The record contains four opinions regarding the cause of claimant's disc protrusion. After experiencing an exacerbation of symptoms in March 1991, claimant sought treatment from Dr. Browning, occupational health specialist, who examined her several times. Dr. Browning previously had treated claimant for neck and back symptoms. (Ex. 59). Dr. Browning stated that claimant's disc protrusion was of "undetermined etiology" and could be related to the 1982 injury, a 1987 fall or a prior motor vehicle accident. (Ex. 82).

Drs. Gardner, neurologist, and Lohman, orthopedic surgeon, conducted an independent medical examination. They concluded that the disc herniation revealed by an MRI scan was not "related to her October 18, 1982 injury, since this same disc herniation would have been seen on the Metrizamide myelogram, performed on May 10, 1985, 2-1/2 years following her injury. Thus, the relationship of her current finding of herniated disc at C4-5 to the original pain in 1982 is obscure." (Ex. 79-7).

Dr. Tilson, orthopedic surgeon, also had previously treated claimant but, on this occasion, examined claimant only one time. He stated that "there is a direct causal relationship between her current pain condition * * * and the cited industrial incident of 10-18-82" and that "although her current pain condition may represent 'waxing and waning' of disc disease the disc disease in and of itself is the direct and proximate result of the industrial injury * * *." (Ex. 76). He disagreed with the report of Drs. Gardner and Lohman, reiterating that he "felt that the cited 10-18-82 * * * incident is the single and principle [sic] initiating factor in an otherwise healthy and active person and that her ongoing symptoms and need for treatment are the direct and proximate result of that incident." (Ex. 80).

Dr. Jacobs, occupational health specialist, examined claimant twice on referral from Dr. Browning. He initially stated that "it is reasonable to postulate that these findings on the MRI [which revealed the disc protrusion] are not at all to be expected in a 26 yr. old and are related to her prior cervical spine trauma." (Ex. 75-3). Dr. Jacobs, however, subsequently agreed with the report of Drs. Gardner and Lohman. (Ex. 81).

Like the Referee, we find Dr. Jacobs' opinion to be inconsistent in that he first related claimant's herniated disc to her 1982 injury and then agreed with the IME report finding that the condition was not related to the injury. Thus, we find his reports to be unconvincing. Furthermore, we disagree with claimant and the Referee that Dr. Tilson is claimant's "main treating physician." Although, like Dr. Browning, Dr. Tilson previously treated claimant, he saw claimant on only one occasion since the discovery of the herniated disc and himself indicated that Drs. Browning and Jacobs were the treating physicians, (Ex. 76-1). Thus, we find that Dr. Tilson's opinion is not entitled to deference as the treating physician.

Finally, we conclude that claimant did not carry her burden in proving compensability of her herniated disc. Although neither Dr. Browning, Drs. Gardner and Lohman, nor Dr. Tilson offer much explanation to support their opinions, Dr. Tilson is the only physician relating this condition to claimant's 1982 industrial injury. Furthermore, Dr. Tilson provides no explanation why other events did not cause the herniated disc when Dr. Browning found that these events could also have contributed to the condition. At best, we find that evidence concerning causation of the herniated disc is in equipoise. Because claimant is required to prove her claim by a preponderance of evidence, we conclude that she did not carry her burden.

ORDER

The Referee's order dated April 7, 1992 is affirmed.

December 31, 1992

Cite as 44 Van Natta 2560 (1992)

In the Matter of the Compensation of
WILLIAM R. ARNETT, Claimant
 WCB Case Nos. 91-15122 & 91-14150
 ORDER ON REVIEW
 Schneider & DeNorch, Claimant Attorneys
 Williams, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of those portions of Referee Podnar's order that: (1) set aside its denial of claimant's right neck, shoulder, and arm condition as an occupational disease; and (2) found that the claim should be classified as disabling. On review, the issues are compensability and claim classification. 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" concerning the issue of compensability.

Claim Classification

Claimant's compensable January 25, 1991 injury was found by Determination Order and Order on Reconsideration to be nondisabling. At hearing, claimant requested that, if his claim was determined to be compensable as a consequence of his existing compensable low back claim, then his claim should be reclassified as disabling. (Tr. 1-2). Having concluded that claimant's claim was compensable as a "new" occupational disease rather than as a compensable consequence, the Referee nevertheless proceeded to address the issue whether the "new" occupational disease claim was disabling or nondisabling. We conclude that, in the event his claim was determined to be compensable as a "new" occupational disease, claimant did not seek to have the Referee classify the claim. Moreover, a dispute over whether a claim is disabling or nondisabling must first be considered by the Department before jurisdiction exists in the Hearings Division to address the issue. See Christine A. Degrauw, 44 Van

Natta 91 (1992). Accordingly, we vacate that portion of the Referee's order that found claimant's "new" occupational disease to be disabling.

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 \$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 to claimant of the benefits secured.

ORDER

The Referee's order dated January 21, 1992 is affirmed in part and vacated in part. That portion of the Referee's order that found that claimant's "new" occupational disease claim is disabling is vacated. The remainder of the Referee's order is affirmed. For services on review, claimant's attorney is awarded a reasonable assessed attorney fee of \$750, to be paid by the insurer.

December 31, 1992

Cite as 44 Van Natta 2561 (1992)

In the Matter of the Compensation of
JERRY M. BANKS, Claimant
WCB Case No. 91-01564
ORDER ON REVIEW
Yturri, et al., Claimant Attorneys
Roy Miller (Saif), Defense Attorney
Norman F. Kelley, Assistant Attorney General

Reviewed by Board Members Brazeau and Neidig.

B & G Logging requests review of Referee Galton's order that: (1) found that B & G was an Oregon employer; (2) found that claimant was a subject worker of B & G; and (3) set aside the SAIF Corporation's denial (on behalf of the Compliance Section for the Workers' Compensation Division) of claimant's claim for a right shoulder injury. With its brief, B & G submits "Appendix A," which contains evidence not admitted at hearing. We treat B & G's submission as a request for remand. On review, the issues are remand, subjectivity and compensability. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Remand

On review, B & G has submitted additional information not admitted at the time of hearing. In response, claimant requests that we strike the portions of B & G's brief that refer to the additional information.

We may remand a case to the Referee for further evidence taking if we determine that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). To merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986). We consider B & G's request that we admit additional documents into the record as a motion for remand. In this regard, we consider the proffered evidence on review only for purposes of addressing the employer's motion for remand.

B & G has submitted a statement taken for insurance purposes from claimant dated May 16, 1990, which describes the circumstances surrounding the industrial injury. We conclude that B & G's explanation regarding why the statement was not produced at the May 15, 1991 hearing fails to establish that the document is material evidence which was not obtainable with due diligence at the time of

hearing. Accordingly, B & G's motion to remand is denied. Claimant's motion to strike those portions of the employer's brief which refer to the documents submitted on review is granted.

Constitutionality of ORS 656.126

Because it was unable to determine whether claimant was a subject worker, the Department referred claimant's injury claim to SAIF without issuing a noncomplying employer order (NCE). See ORS 656.054. At hearing, the Department acknowledged that it needed to issue a NCE order. The Referee concluded that, because both SAIF and the Department were present at hearing, he could direct SAIF to process the claim, notwithstanding the lack of a NCE order. Consequently, finding that claimant was a subject worker for B & G, who was an Oregon employer, the Referee set aside SAIF's denial and directed SAIF to process the claim.

ORS 656.126 provides that, in certain circumstances, workers temporarily in or out of the state will be entitled to workers' compensation benefits. We agree with the Referee that ORS 656.126 applies and that B & G is an Oregon employer because its workplace in Oregon was not "temporary." ORS 656.126(2), (6).

On review, B & G argues that ORS 656.126, as amended in 1989, is unconstitutional. B & G contends that the statute is unconstitutional because it is a violation of the Oregon State Constitution and the Equal Protection Clause.

The record does not establish that B & G argued, at the time of hearing, the constitutionality of ORS 656.126. For that reason, we decline to consider B & G's argument as raised for the first time on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). Moreover, had we entertained B & G's argument on review, we would not have found it persuasive. See Peacock v. Veneer Services, 113 Or App 732 (1992) (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.)

Reciprocity agreement

On review, B & G refers to a reciprocity agreement between the states of Oregon and Idaho. B & G also, however, concedes that the new reciprocity agreement was not approved by the Attorney General's Office. Accordingly, because we find insufficient evidence that a valid reciprocity agreement exists between the two states, we reject any argument that B & G and claimant were exempt from the provisions of ORS 656.126 due to such an agreement. See ORS 190.430 (requiring Attorney General approval before reciprocity agreements take effect); and ORS 656.126(5) (requiring reciprocity agreements to be executed and made public by the respective state agencies).

Subjectivity

The Referee concluded that claimant was a subject worker and B & G was an Oregon subject employer. On review, the employer concedes that it worked at the Oregon site for more than 30 days in 1990. Accordingly, having rejected B & G's arguments with regard to constitutionality and reciprocity, we conclude that the employer is not excused from providing the requisite workers' compensation benefits since, in 1990, it did not have a "temporary" workplace within the state of Oregon. See ORS 656.126; OAR 436-50-055(1)(d). We, therefore, adopt the Referee's "Conclusions and Opinion" on the issue of subjectivity.

Compensability

The Referee concluded that claimant had established compensability of his shoulder condition, either as an industrial injury or an occupational disease. B & G argues that the opinion of Dr. Lewis, claimant's treating orthopedic surgeon, is not persuasive as Dr. Lewis did not have a complete history. Specifically, B & G asserts that Dr. Lewis was not aware of the extensiveness of claimant's off-work weightlifting activities. B & G also contends that Dr. Lewis was unaware of claimant's past history of headaches and dizziness in 1985.

We conclude that Dr. Lewis' opinion is persuasive. As claimant's treating physician and the doctor who operated on his shoulder, we conclude that Dr. Lewis is in the best position to provide an opinion regarding the cause of claimant's condition. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988). Moreover, we find that, even if Dr. Lewis was not provided with claimant's records from Dr. Harsh, the lack of information regarding a dizziness and headache condition in 1985 would not

negate the persuasiveness of his opinion regarding claimant's shoulder impingement syndrome, which apparently began in 1989.

We also find that Dr. Lewis was aware of claimant's weightlifting program. He explained why he believed that claimant's condition was primarily due to his repetitive work activities, rather than his off-work weightlifting activity. Dr. Lewis also permitted claimant to continue with his weightlifting program during his course of treatment for his shoulder condition. Finally, after comparing claimant's work activity with the kind of athletic activity he engaged in, Dr. Lewis stated that claimant's repetitive work as a timber faller was the major contributing cause of his shoulder impingement syndrome.

For the foregoing reasons, we conclude that the Referee correctly found that claimant's work is the major contributing cause of his right shoulder condition.

Claims processing/noncompliance order

The Referee set aside the denials issued by SAIF and B & G and remanded the claim to SAIF for acceptance and processing. Although the matter has not been specifically raised on review, we find that, as a result of our de novo review, the Referee's processing directive is properly before us. Furthermore, we find that the issue was specifically raised at hearing, with all parties, including B & G, present.

Following the filing of claimant's Oregon claim, the Department investigated, but was unable to determine whether claimant was a subject worker. Without issuing a NCE order, the Department forwarded the claim to SAIF for processing and recommended that the claim be denied on subjectivity grounds. In its referral to SAIF, the Department stated that it had taken the action in accordance with former OAR 436-80-060(2), which provided as follows:

"(2) When Compliance finds that at the time of the injury, either the worker was not a subject worker or the employer was not a subject employer:

"(a) Compliance shall refer the claim to the SAIF Corporation and advise SAIF of its finding and the basis of its finding;

"(b) SAIF shall deny the claim, basing its denial on the findings of Compliance and any other appropriate grounds, and notify the claimant and employer of its action; and

"(c) The notice shall also inform the worker of the right to a hearing under ORS 656.283."

WCD Admin. Order 4-1989.

Following the referral from the Department, SAIF issued its denial and B & G subsequently issued its own denial. At hearing, counsel for the Department stated that it sought to have SAIF's denial affirmed. However, the Department's counsel also stated that if B & G and claimant were found to be a subject employer and subject worker, respectively,:

"...then I would request rather than you as in your capacity as a referee, making any determination as to the complying or noncomplying status of (the employer), that you simply find that (the employer) is or is not or is a subject employer and then remand the case to the compliance section of the worker's compensation division, etc., for processing. The reason that I ask that is that compliance has not concluded officially whether or not (the employer) is a complying Oregon employer." Tr. 8.

Counsel for SAIF essentially agreed with the Department's position regarding the processing of the claim, (Tr. 20), while neither claimant nor B & G took a specific position on the processing issue.

We conclude that the Department's actions in this case were inconsistent with ORS 656.054, the statutory authority for the processing of such claims. ORS 656.054 provides, in part:

"(1) A compensable injury to a subject worker while in the employ of a noncomplying employer is compensable to the same extent as if the employer had complied with this chapter. The director shall refer the claim for such an injury to the

State Accident Insurance Fund Corporation within 60 days of the date the director has notice of the claim. At the time of referral of the claim, the director shall notify the employer in writing regarding the referral of the claim and the employer's right to object to the claim."

See also James L. Guyton, 41 Van Natta 1277 (1989) (the sole statutory authority for referring a claim against a noncomplying employer is ORS 656.054, which requires the Director to refer a claim to SAIF. There is no statutory authority for a referee to refer such a claim to SAIF for processing.)

Thus, ORS 656.054 presumes that a NCE order has been issued before the claim is referred to SAIF for processing. Moreover, the Department acted outside the scope of its own former administrative rule which first required that Compliance make a determination regarding subjectivity before it refers the claim to SAIF.¹ Former OAR 436-80-060(2). In this case, the Department had not arrived at a decision regarding subjectivity. Instead, the claim was referred to SAIF for processing because the Department was unable to determine whether claimant was a subject worker.

In addition, the Department also failed to follow the provisions of ORS 656.054 when, without issuing a NCE order, it initially forwarded the claim to SAIF to issue its denial without notifying B & G of the referral of the claim, or of its right to object to the claim. Although B & G subsequently received notice by way of SAIF's denial and eventually issued its own denial, we do not find that the result justified the Department's failure to follow the provisions of the statute.

Accordingly, we find that the Department's referral of the claim to SAIF was not statutorily or administratively authorized. Thus, SAIF appeared at the hearing neither on behalf of B & G nor the Department. Notwithstanding this conclusion, SAIF proceeded to issue a compensability denial under the color of its authority pursuant to former OAR 436-80-060(2). As such, SAIF's denial constituted a "matter concerning a claim," which required claimant to request a hearing to contest the denial. ORS 656.283(1); 656.704(3). Moreover, claimant was required to act because he had no other administrative procedure available to him under the laws in effect at the time.²

Considering that SAIF had issued a compensability denial concerning claimant's claim and because SAIF was operating within the color of its authority under former OAR 436-80-060(2), we conclude that the Referee properly proceeded to determine the subjectivity and compensability issues at hearing. However, we conclude that, because a NCE order has never been issued by the Department, responsibility for directing the processing of this claim remains with the Department. ORS 656.054; James L. Guyton, supra. Should the Department issue a NCE order, the claim would then be properly referred to SAIF for processing in accordance with ORS 656.054.

In reaching our conclusion, we note that the issues of subjectivity and compensability have been fully litigated, with all parties present. Our conclusions concerning the issues of subjectivity and compensability will, therefore, likely have significant, if not preclusive, effect on the Department's, and eventually SAIF's, subsequent processing determinations.

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 review is \$900, to be paid by SAIF. Ultimate responsibility for this fee, as well as SAIF's other claim costs, shall rest with B & G if and when it is determined to be a noncomplying employer. ORS 656.054(3). 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

As modified herein, the Referee's order dated October 28, 1991 is affirmed. Responsibility for the further processing of this claim currently rests with the Compliance Section, who will determine whether the issuance of an order finding B & G to be a noncomplying employer under ORS 656.054 is warranted. For services on review, claimant's counsel is awarded an assessed attorney fee of \$900, to be paid by the SAIF Corporation.

¹ The current rules now provide for referral of such a claim to SAIF only upon the issuance of an order of noncompliance. OAR 436-80-060(1).

² Although the rules were not in effect at the time of this case, OAR 436-80-060(3) and OAR 438-80-008(3) now provide that a worker is entitled to seek administrative review from the Department of a determination of nonsubjectivity.

In the Matter of the Compensation of
MARGARET BOEHR, Claimant
WCB Case No. 89-21774
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Ronald Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Moller and Neidig.

Claimant requests review of that portion of Referee Brazeau's order that declined to award an attorney fee for the SAIF Corporation's allegedly unreasonable delay in complying with a request for discovery. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

We adopt the Referee's "Stipulated Facts," and add the following supplementation.

On July 24, 1989, SAIF received claimant's discovery request for documents. On August 29, 1989, SAIF sent the requested documents to claimant.

On October 30, 1989, claimant requested a hearing. The sole issue raised by the hearing request was entitlement to penalties and attorney fees for SAIF's allegedly unreasonable discovery delay.

CONCLUSIONS OF LAW AND OPINION

On remand, the Referee found that the parties agreed that claimant's claim had been accepted and was, therefore, compensable. The Referee reiterated his prior conclusion that SAIF had 15 days from the date claimant mailed her demand for discovery to supply the requested information. In this case, the Referee found that SAIF had offered no explanation for its failure to timely reply. He therefore continued to conclude that SAIF's conduct was unreasonable. Finally, the Referee concluded that, because all compensation to which claimant was entitled had been paid at the time of the discovery violation, there could be no unreasonable resistance to the payment of compensation. For that reason, the Referee declined to award an attorney fee pursuant to ORS 656.382(1).

On review, claimant argues that the Referee did not follow the Court of Appeals' holding in Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991). Claimant contends that once the Referee found the underlying claim to be compensable and SAIF's conduct to have been unreasonable, the Boehr case required the Referee to award an assessed attorney fee pursuant to ORS 656.382(1).

SAIF does not disagree that the underlying claim is compensable. However, SAIF contends that the Referee should have analyzed the alleged discovery violation under the Department's rule, former OAR 436-10-030(10), rather than the Board's discovery rule, former OAR 438-07-015(2). We agree.

In Boehr, the court found that the Board's Order on Review correctly concluded that former OAR 438-07-015(2), which requires compliance within 15 days of a discovery request, did not apply because the discovery request was made before a request for hearing was filed. Boehr, supra; O'Leary v. Valley View Cutting, 107 Or App 103 (1991). The court agreed with the Board that former OAR 436-10-030(10) was the applicable rule. Accordingly, the court directed the Board, on remand, to determine whether SAIF's delay was unreasonable.

Although the Referee's order analyzed the alleged discovery violation under the Board's rule, rather than the Department's rule, we find the record to be sufficiently developed for purposes of review with regard to the issue. As noted by the court in Boehr, we have previously concluded that although former OAR 436-10-030 does not include any express time limit for responding to discovery requests, we have interpreted the rule to require that documents be produced in a reasonable time under the circumstances surrounding the discovery request. Lawrence A. Durette, 42 Van Natta 413 (1990).

In Durette, we concluded that SAIF assigned a lower priority to copying of documents in claims where there was no pending hearing request and, as a result, the turnover time in producing such documents was usually 15 days or longer. We found that, absent any special circumstances necessitating more prompt disclosure, SAIF's production of the documents within 22 days of the request was reasonable. Lawrence A. Durette, supra.

Here, SAIF provided the documents to claimant within 35 days of claimant's request. Claimant received the documents in late August 1989. However, claimant's hearing request was not filed until October 30, 1989, and the sole issue raised for hearing was entitlement to a penalty and attorney fee. Additionally, claimant never filed a request for hearing on the issue of compensability, and her claim was accepted and processed by SAIF. But see Robert C. Smith, 42 Van Natta 899 (1990) (when claim is neither accepted nor denied within 60-day statutory period, a 30 day delay in providing discovery pursuant to Director rule due to clerical error found unreasonable). Finally, the record contains no evidence that would demonstrate a need for more prompt disclosure than was provided in this case. See Lawrence A. Durette, supra; Maria Ballard, 43 Van Natta 1183 (1991).

Under the circumstances, we do not find SAIF's production of discovery within 35 days of the request to constitute an unreasonable delay. Accordingly, although the underlying claim is compensable, we find no failure to comply with discovery requirements and no unreasonable resistance to the payment of compensation to justify an attorney fee pursuant to ORS 656.382(1). The Referee's order is therefore affirmed.

ORDER

The Referee's order dated April 8, 1992, as reconsidered by the April 20, 1992 order, is affirmed.

December 31, 1992

Cite as 44 Van Natta 2566 (1992)

In the Matter of the Compensation of
STEVEN B. CALDWELL, Claimant
WCB Case No. 91-13248
ORDER ON REVIEW
Miller, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The insurer requests review of Referee Lipton's order that directed it to calculate claimant's rate of temporary disability benefits based on his average earnings for the five week period prior to his injury. On review, the issue is rate of temporary disability benefits. We modify.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact, with the exception of the last paragraph in that section.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that there were extended gaps in claimant's pay periods during prior work cycles in the 26 week period before his injury. He therefore concluded that claimant's wages, for purposes of determining rate of temporary disability, should be based upon the average weekly earnings during the five weeks claimant worked prior to the injury.

On review, the insurer contends that the periods not worked by claimant during his employment did not constitute "extended gaps" for purposes of calculating temporary disability benefits. We agree.

Former OAR 436-60-025(4)(a) provides:

"For workers employed on call, paid by piece work or with varying hours, shifts or wages, insurers shall use the worker's average weekly earnings for the previous 26 weeks unless periods of extended gaps exist. When such gaps exist, insurers shall use no less than the previous four weeks of employment to arrive at an average. For workers employed less than four weeks, or where extended gaps exist within the four weeks, insurers shall use the intent at time of hire as confirmed by the employer and the worker."

Determining what is an "extended gap" is not based solely upon the length of the break in work, but must also be based on whether the gap has caused a change in the work relationship between employer and employee. Craig E. Hobbs, 39 Van Natta 690 (1987). Whether extended gaps in a claimant's employment exist should be determined on a case-by-case basis. Dena L. Barnett, 43 Van Natta 1776 (1991).

Here, claimant's work schedule varies, depending upon how many days he drives during each two-week period. His pay also varies depending upon the route he drives. Claimant's work schedule varies at least every three months. During different pay periods, he may work as many as 12 days or as little as 1 day.

We agree with the insurer that this case is similar to Eugene C. Brown, 43 Van Natta 1920 (1992), in which we held that although the claimant's employment contained two weeks with no earnings and seven weeks with earnings of less than \$200, those periods of time did not constitute "extended gaps." In Brown, we held that the record did not demonstrate that the work relationship was altered or wage expectations changed due to his varying work schedule.

In the present case, we are unable to find that claimant's work schedule contained extended gaps which caused a change in the work relationship between claimant and the employer. Rather, the evidence in this case establishes that claimant's varying work schedule and number of days on or off work were within the reasonable expectations of claimant and the employer. Tr. 18, 21. See Adam J. Delfel, 44 Van Natta 514 (1992). We therefore conclude that the rate of temporary disability benefits should be based on claimant's average weekly earnings for the 26 weeks of employment prior to the injury.

ORDER

The Referee's order dated March 11, 1992, as reconsidered by the April 9, 1992 order, is modified. The rate of claimant's temporary disability benefits will be based on his average weekly earnings for the 26 weeks prior to the date of injury.

December 31, 1992

Cite as 44 Van Natta 2567 (1992)

In the Matter of the Compensation of
LARRY E. COLLMAN, Claimant
WCB Case No. 91-01794
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Roberts, et al., Defense Attorneys

Reviewed by Board Members Gunn and Brazeau.

The self-insured employer requests review of Referee Michael V. Johnson's order that set aside its partial denial of claimant's claim for his psychological condition. In his brief, claimant contends that if the claim is not compensable as a consequential condition, it is compensable because psychological treatment is necessary to assist his return to work. Claimant also argues that the Referee's attorney fee award at hearing was inadequate. 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 the last paragraph of page 4, all of page 5, and the first paragraph of page 6.

CONCLUSIONS OF LAW AND OPINION

Compensability

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

On review, the employer argues that the Referee should not have deferred to the opinion of claimant's treating psychiatrist, Dr. Brown. The employer contends that Dr. Brown is not persuasive because claimant had other stressors (such as divorce) in addition to stress from his injury, yet Dr.

Brown believed that claimant was an "exception" to the rule that the stress from divorce would be a primary cause of his depression.

We conclude that the Referee properly gave deference to Dr. Brown's opinion. As noted by the Referee, Dr. Brown treated claimant on more than twenty occasions. Dr. Brown noted that Dr. Orwick, claimant's treating doctor, had originally reported claimant's depression following the compensable injury. Furthermore, while Dr. Brown acknowledged that the non-work stressors had an impact on claimant, he adequately explained why, in claimant's case, the injury was the major cause of his depression. Ex. 93 pgs. 14-31.

Under the circumstances, we conclude that the Referee correctly deferred to the treating doctor, rather than to the opinion of Dr. Parvaresh, an independent medical examiner who examined claimant upon only one occasion. We therefore agree that claimant has established that the compensable injury is the major contributing cause of his consequential psychological condition.

Because we have found claimant's condition compensable pursuant to ORS 656.005(7)(a)(A), we need not address claimant's alternative theory of compensability.

Attorney fees/hearing

On review, claimant argues that the Referee's attorney fee award of \$3,200 for services at hearing was inadequate. Claimant has not disputed the Referee's findings regarding the number of attorney hours spent on this case, the length of the hearing and the number of depositions.

After reviewing the record and 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 was reasonable. We, therefore, decline to increase the attorney fee awarded at hearing.

Attorney fees/Board level

Claimant is entitled to an assessed attorney fee for prevailing over the insurer's request for review on the issue of compensability. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable attorney fee for claimant's attorney's services on review concerning the issue of compensability is \$1,500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by that portion of claimant's respondent's brief and statement of services), the complexity of the issue and the value of the interest involved. We note that no attorney fee award is available for that portion of claimant's brief devoted to the attorney fee issue.

ORDER

The Referee's order dated April 27, 1992 is affirmed. For services on review concerning the issue of compensability, claimant's counsel is awarded an attorney fee of \$1,500, to be paid by the self-insured employer.

In the Matter of the Compensation of
KURT D. CUTLIP, Claimant
WCB Case Nos. 91-13835 & 91-12437
ORDER ON REVIEW
Westmoreland & Shebley, Claimant Attorneys
Charles A. Ringo, Defense Attorney
Miller, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Hooton.

Claimant requests review of those portions of Referee Spangler's order that: (1) upheld Liberty Northwest Insurance Corporation's (Liberty) denial of his aggravation claim for his current left knee condition; (2) upheld Crawford and Company's (Crawford) denial insofar as it denied the compensability of claimant's claim for the same condition; (3) declined to award interim compensation payable by Crawford; (4) declined to assess a penalty for Crawford's allegedly unreasonable refusal to pay interim compensation; and (5) awarded an assessed attorney fee of \$800 for prevailing over Crawford's denial insofar as it denied claimant's "new injury" claim. On review, the issues are compensability, responsibility, interim compensation, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the "FINDINGS OF FACT" section of the Referee's order, with the following supplementation.

The May 28, 1991 work incident was a material contributing cause of claimant's subsequent disability and need for treatment. Crawford did not pay claimant any interim compensation prior to issuing its denial on August 26, 1991.

CONCLUSIONS OF LAW AND OPINION

Compensability/Responsibility

Liberty accepted claimant's claim for a left knee injury occurring in 1986; therefore, Liberty remains responsible for the left knee condition, unless it establishes that claimant sustained a new compensable injury involving the left knee condition while working for Crawford's insured. See ORS 656.308(1); Rosalie S. Drews, 44 Van Natta 36 (1992); Ricardo Vasquez, 43 Van Natta 1678 (1991). To establish a new compensable injury, Liberty must prove that work exposure with Crawford's insured is a material contributing cause of claimant's disability and need for treatment. See Rosalie S. Drews, supra; Mark N. Wiedle, 43 Van Natta 855 (1991).

We conclude that Liberty carried its burden of proving that claimant sustained a new compensable injury while working for Crawford's insured on May 28, 1991. Claimant persuasively testified that he experienced severe knee pain on May 28, 1991, when he squatted down to pick up something and attempted to stand again. (Tr. 29). He felt like his knee "exploded" and he was unable to stand. His leg was immobilized and he was taken immediately to the emergency room, where he was examined and diagnosed with a left knee strain. (Tr. 30-31; Ex. 36). An MRI scan revealed a complex tear of the posterior horn and body of the medial meniscus. (Ex. 41). He was subsequently released from work, and surgery was recommended. (Exs. 42, 43, 46).

The medical evidence on the issue of causation is divided. Dr. Peterson opined that the May 1991 work incident was the major contributing cause of claimant's knee condition. (Exs. 47, 51, 57). Drs. Fuller and Logan opined that claimant's preexisting knee condition was the major contributing cause of his condition following the May 1991 incident. (Exs. 48, 54, 55). Dr. Fuller later concurred that there was no medical evidence supported by objective findings that the May 1991 incident materially contributed to his subsequent knee condition and need for treatment. (Ex. 56).

We are not persuaded by the opinions of Drs. Fuller and Logan for the following reasons. Fuller's opinion is based on history that claimant's knee symptoms following the May 1991 incident were no more severe than symptoms before the incident. (Ex. 54-2). That is contradicted by claimant's persuasive testimony that, although he occasionally experienced knee symptoms before the May 1991 incident, the pain following the incident was so severe that he had to be helped into a wheelchair and transported to the emergency room. (Tr. 26-30). Claimant added that he lost no time from work with

Crawford's insured due to the knee condition until the May 1991 incident. (Tr. 28). We discount Logan's opinion because it was based on application of the "major contributing cause" standard, rather than the "material contributing cause" standard for establishing a compensable injury. (Ex. 55).

We are mindful that Dr. Peterson also relied on an erroneous history, believing that claimant had been asymptomatic for two and one-half years following knee surgery in July 1987. (Ex. 51). That erroneous history certainly undercuts Peterson's opinion that the May 1991 incident was the major cause of claimant's condition. However, as we noted above, the critical inquiry is whether the May 1991 incident was a material contributing cause of subsequent disability and need for treatment.

We conclude that Peterson's opinion and claimant's testimony are sufficient to prove that the May 28, 1991 work incident was a material contributing cause of subsequent disability and need for treatment. We also find that the May 28, 1991 injury is established with medical evidence supported by objective findings. See Georgia-Pacific Corp. v. Ferrer, 114 Or App 471 (1992). Accordingly, responsibility for "all further compensable medical services and disability" involving the left knee condition shifts to Crawford. See ORS 656.308(1); Rosalie S. Drews, supra.

The Referee found that claimant had sustained a new compensable injury with Crawford's insured on May 28, 1991. However, the Referee then applied ORS 656.005(7)(a)(B) based on a finding that claimant's left knee condition prior to the new injury was a "preexisting condition" which combined with the May 28, 1991 injury to cause disability and need for treatment. Finding that the "preexisting condition," not the May 28, 1991 injury, is the major contributing cause of claimant's resultant condition, the Referee concluded that the resultant disability and need for treatment are not compensable. We disagree.

In Rosalie S. Drews, supra, we held that ORS 656.005(7)(a)(B) is not applicable to the assignment of responsibility under ORS 656.308(1). Furthermore, subsequent to the Referee's order, in John L. Law, 44 Van Natta 1091, 1092, recon 44 Van Natta 1619 (1992), we held that a prior compensable injury is not a "preexisting disease or condition" within the meaning of ORS 656.005(7)(a)(B). Rather, we interpreted that phrase to mean a noncompensable preexisting condition which combines with a compensable injury. Id.

Inasmuch as claimant's left knee condition prior to the May 28, 1991 incident was compensable, we do not apply ORS 656.005(7)(a)(B) to limit Crawford's liability for claimant's left knee condition. Accordingly, based on the material contributing cause standard, we conclude that Crawford is responsible for all further disability and treatment relating to the left knee condition.

Interim Compensation

The Referee concluded that Crawford was not liable for the payment of interim compensation because claimant's left knee condition was not compensable. Claimant argues that the Referee erred in making his entitlement to interim compensation contingent on the compensability of the injury claim. We agree.

ORS 656.262(4)(a) requires an insurer to begin paying interim compensation within 14 days after receiving notice or knowledge of a claim. A worker who has left work due to a claimed injury or condition is entitled to interim compensation, whether or not the claim is ultimately found compensable, until the insurer denies the claim. See Bono v. SAIF, 298 Or 405 (1984); Jones v. Emanuel Hospital, 280 Or 147, 151 (1977); Nix v. SAIF, 80 Or App 656, 659, rev den 302 Or 158 (1986).

Here, Crawford's insured had knowledge of the May 28, 1991 injury on the day it occurred. That knowledge is legally attributable to Crawford. See Nix v. SAIF, supra, 80 Or App at 660; Anfilofieff v. SAIF, 52 Or App 127 (1981). Because claimant left work due to the injury, Crawford was liable for the payment of interim compensation beginning 14 days after the date of injury until it denied the claim on August 26, 1991.

Penalties

Crawford's failure to pay interim compensation is unexplained and, therefore, unreasonable. Accordingly, we assess a penalty against Crawford in the amount of 25 percent of all amounts of interim compensation due and owing from the date of the May 28, 1991 injury through the date of the August

26, 1991 denial. See ORS 656.262(10)(a); Jones v. Emanuel Hospital, supra, 280 Or at 152. The penalty shall be paid in equal shares to claimant and his attorney.

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 concerning the compensability issue is \$3,500, to be paid by Crawford. This award is in lieu of the Referee's attorney fee award. 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 January 2, 1992, as reconsidered January 28, 1992, is reversed in part and affirmed in part. That portion of the order that upheld Crawford and Company's denial insofar as it denied claimant's resultant left knee condition is reversed. Crawford's denial is set aside in its entirety, and the claim is remanded to Crawford for processing according to law. Crawford is assessed a penalty equal to 25 percent of all interim compensation due from May 28, 1991 through August 26, 1991, payable in equal shares to claimant and his attorney. In lieu of the Referee's attorney fee award, claimant's attorney is awarded an assessed fee of \$3,500 for services at hearing and on review, payable by Crawford. The remainder of the order is affirmed.

December 31, 1992

Cite as 44 Van Natta 2571 (1992)

In the Matter of the Compensation of
JANIE M. DAVIS, Claimant
 WCB Case No. 91-08645
 ORDER ON REVIEW (REMANDING)
 Doble & Associates, Claimant Attorneys
 Bottini & Bottini, Defense Attorneys

Reviewed by Board Members Hooton and Kinsley.

Claimant requests review of that portion of Referee Galton's order which upheld the insurer's denial of temporary disability benefits. On review, claimant also moved to remand the case to the Referee to consider additional evidence allegedly pertaining to claimant's credibility. On review, the issues are motion to remand and temporary disability. We remand.

FINDINGS OF FACT

On September 28, 1987, claimant sustained a compensable industrial injury to her neck and upper left back, which EBI accepted on October 22, 1987. (Ex. 1).

On April 21, 1989, Dr. Silver, neurosurgeon, performed an anterior cervical discectomy and interbody fusion due to a herniated disc at C5-6 and C6-7. (Ex. 12). He released claimant to return to work without limitation on September 5, 1989. (Ex. 14-2).

By Determination Order of October 16, 1989 and Stipulation and Order of February 22, 1990, claimant was granted entitlement to temporary total disability benefits from October 5, 1987 to September 5, 1989, less time worked, and compensation for unscheduled permanent partial disability of 25 percent (80 degrees). (Exs. 19, 20).

On March 19, 1990, Dr. Christensen, consulting chiropractor, reported that claimant had not returned to work, and that she was physically unable to work at that time. (Ex. 21-1, 21-6). By report of July 12, 1990, Dr. Berovic, claimant's treating chiropractor, advised that claimant had told him on February 21, 1990 that she was working in a supervisory position at Dairy Queen. (Ex. 26-1). Dr. Berovic took claimant off regular work, limiting her to sedentary work with restrictions. (Ex. 26-2).

On December 26, 1990, Referee Crumme' issued an Opinion and Order in WCB Case No. 90-08814 affirming EBI's April 11, 1990 denial of claimant's aggravation claim. (Ex. 33).

Dr. Nelson, claimant's treating osteopath, referred claimant for evaluation and treatment to psychologist Dr. Fleming, Ph.D. (Exs. 36, 37-1). Dr. Fleming examined claimant on March 14, 1991, at which time she told him she had not returned to work since her surgery in April 1989, but that her vocational plans included some type of office work. (Ex. 37-2, 37-4).

At EBI's request on June 19, 1991 a panel of physicians at Medical Consultants Northwest (the MCN) performed an independent medical examination. (Ex. 40). The examining osteopath and neurologist reported that claimant worked at Dairy Queen after her work release following the April 1989 surgery, until she was restricted from working by her chiropractic physician. (Ex. 40-6, see also Ex. 40-3). They also reported that claimant was currently not employed, and had no specific return to work goals. (Ex. 40-2, 40-8). During the psychiatric evaluation with Dr. Altfas at the MCN, claimant detailed her usual daily activities, which included no mention of work. (Ex. 40-10).

Claimant's condition objectively worsened on September 19, 1991, as documented by Dr. Frank, assistant professor of neurosurgery at the Oregon Health Sciences University. (Ex. 56). He recommended she have a re-fusion at C6-7. (Ex. 56-2).

EBI authorized the surgery and reopened the claim for aggravation effective September 24, 1991, simultaneously denying that claimant was entitled to temporary disability benefits on the ground that she was not a member of the work force. (Ex. 59A). The parties subsequently stipulated that the reopening is effective September 19, 1991. (Tr. 2).

Claimant's surgery was scheduled for October 9, 1991. (Ex. 59A). Claimant testified that Dr. Frank was unable to perform the surgery on the originally scheduled date in October. (Tr. 35-36). Although Dr. Frank offered to reschedule the surgery in December 1991, claimant chose to postpone it until January 15, 1992. (Exs. 61, 62; Tr. 36).

Claimant provided to the insurer a list of employers she had contacted for work between May and August 1990; the list is not in evidence. She testified at hearing about other job search efforts that she had not previously listed. (Tr. 38-42). She testified that she worked approximately four days for Dr. Brown, a chiropractor, in 1991. (Tr. 22-24). Claimant also testified that she worked for her daughter-in-law, Lisa Moore, in home day care from approximately April until July 1991. (Tr. 26-27).

CONCLUSIONS OF LAW AND OPINION

After a hearing on March 6, 1992, the Referee found that claimant was not employed during 1991, was not willing to work, and did not make reasonable efforts, which would not have been futile, to obtain employment. His findings were based on the conclusion that claimant's testimony regarding her work history and job search efforts was neither credible nor reliable. Accordingly, the Referee concluded that claimant was not a member of the work force at the time of her aggravation in September 1991, and therefore, not entitled to temporary disability benefits.

On review, claimant moved to remand this case to the Referee for further consideration with respect to his credibility findings. In support of the motion, claimant submitted medical evidence showing that on March 18, 1992 she sought treatment for problems with her voice, diagnosed as true vocal cord paralysis, which developed after claimant's January 1992 cervical spine fusion surgery. Claimant contends this evidence bears directly on the Referee's credibility findings based on claimant's demeanor at hearing, including his assessment of her "tone, inflection, and speed/hesitation" while testifying. Opinion and Order at 3.

Our review is limited to the record developed at hearing. ORS 656.295(5). Therefore, we are not authorized to consider the evidence submitted by claimant on review. However, we may remand to the Referee should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." Id.

Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be shown that material evidence was not obtainable with due diligence at the time of the

hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986); Bernard L. Olson, 37 Van Natta 1054 (1986), aff'd mem., 80 Or App 152 (1986). We consider the proffered evidence only to determine whether remand is appropriate.

The Referee's decision turns on his assessment of claimant's credibility. Among the factors discussed by the Referee in making claimant's credibility assessment was her attitude, appearance and demeanor at hearing, including "her tone, inflection, and speed/hesitation" while testifying. Opinion and Order at 3.

We find that the Referee's assessment of claimant's credibility based on her demeanor is critical in deciding whether claimant's testimony is believable. We further find that the new evidence proffered by claimant bears directly on the Referee's assessment of her demeanor, because he specifically identified claimant's voice qualities as factors he considered in assessing her credibility. Therefore, we conclude that the record before the Referee was incompletely developed and remand is appropriate. See Robert D. Blanchfield, Jr., 44 Van Natta 2139, recon 44 Van Natta 2276 (1992). Moreover, we find that the evidence could not have been obtained with due diligence at the time of the hearing, since the evidence was generated after the hearing when claimant sought treatment for problems with her voice.

Because we remand this matter to the Referee, we do not reach the question of the date on which temporary disability benefits should begin, in the event that claimant is found to be in the work force at the time of her aggravation.

This matter is remanded to Referee Galton for further proceedings to: (1) admit the additional post-hearing evidence, as well as grant the insurer an opportunity to cross-examine this evidence or present rebuttal evidence; and (2) determine whether and to what extent the new evidence affects the ultimate outcome in this case. These further proceedings may be conducted in any manner that the Referee determines will achieve substantial justice. Following these further proceedings, the Referee shall issue a final, appealable order concerning the issues raised in this case.

ORDER

The Referee's order dated March 10, 1992 is vacated. This case is remanded to Referee Galton for further proceedings consistent with this order.

December 31, 1992

Cite as 44 Van Natta 2573 (1992)

In the Matter of the Compensation of
ELLA M. DeCOTEAU, Claimant
WCB Case Nos. 91-16356 & 91-16355
SECOND ORDER OF DISMISSAL
Francesconi & Associates, Claimant Attorneys
Davis & Bostwick, Defense Attorneys
Cummins, et al., Defense Attorneys

On December 3, 1992, we withdrew our November 13, 1992 order which had dismissed Cigna Insurance's request for review of a Referee's order. We took this action to retain jurisdiction over this case while claimant and Alexis Risk Management prepared a revised proposed disputed claim settlement for our consideration. Having received that revised agreement, we proceed with our review.

The proposed settlement is designed to resolve all issues raised or raisable in this matter between claimant and Alexis, in lieu of the Referee's order. Specifically, claimant agrees that Alexis' denial "shall be affirmed in its entirety." Furthermore, based on the representations contained in the addendum to the parties' settlement, the Board finds extraordinary circumstances to justify the award of an attorney fee in excess of the schedule set forth in OAR 438-15-050.

Pursuant to the settlement, claimant and Alexis agree that this matter shall be dismissed with prejudice. We have approved the agreement, thereby fully and finally resolving this dispute, in lieu of the Referee's order. In granting this approval, we republish our November 13, 1992 order (as

supplemented herein), which documented our approval of a disputed claim settlement between Cigna Insurance and claimant.

In accordance with the aforementioned settlements, this matter is dismissed with prejudice.

IT IS SO ORDERED.

December 31, 1992

Cite as 44 Van Natta 2574 (1992)

In the Matter of the Compensation of
EDWARD M. EDDINGTON, Claimant
WCB Case No. 91-08823
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Gunn.

Claimant requests review of Referee Barber's order that: (1) upheld the insurer's denial of claimant's aggravation claim; (2) found that claimant was not entitled to interim compensation; and (3) declined to award a penalty and attorney fee for an allegedly unreasonable denial. On review, the issues are aggravation, interim compensation, 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

Aggravation

In order to establish the compensability of a claim for aggravation, claimant must establish that he has suffered a worsening of his compensable condition since the last award or arrangement of compensation. The worsening must be established by medical evidence supported by objective findings. ORS 656.273(1), (3).

The Referee found that claimant's aggravation claim failed on the basis that no objective findings of a worsening had been established. The Referee relied on Dr. Carr's assessment of what constituted "objective findings" for purposes of this claim. Carr stated that range of motion, sensory and strength testing results did not constitute objective evidence.

Claimant challenges the Referee's reliance on Dr. Carr, asserting that Carr's definition of "objective findings" is not relevant to this proceeding. Claimant also asserts that sufficient objective findings of a worsening have been established. We agree with claimant on both points.

Under ORS 656.005(19), "objective findings" include "range of motion, atrophy, muscle strength, muscle spasm and diagnostic evidence substantiated by clinical findings." Furthermore, in Suzanne Robertson, 43 Van Natta 1505 (1991), we interpreted the "objective findings" requirement to be satisfied if a physician examines the worker and, based on that examination, finds that the worker suffers from a disability or a physical condition that requires medical services. Id. at 1507.

We have also held that "objective findings" is a legal term, not a medical term, and that a physician's opinion that his findings do not constitute objective findings is not relevant if those findings otherwise satisfy ORS 656.005(19). Craig H. Ayer, 43 Van Natta 2619 (1991), aff'd mem SAIF v. Ayer, 116 Or App 515 (1992).

In this case, claimant compensably injured his low back in 1989. In May 1991, while bending down, claimant experienced another episode of low back pain. Claimant was examined by Dr. Carr, who found "some generalized tenderness in the left lumbosacral area" and that claimant could flex approximately 30 degrees. (Ex. 38-1). Dr. Carr also found that "motor testing reveals some possible EHL weakness on the left side" and that "sensory examination reveals generalized hypesthesias but no true sensory loss on the left side." (Id.) Dr. Carr recommended bed rest for two or three days and

physical therapy if claimant's condition showed some improvement within one week. (Id.) An MRI was then performed, showing no evidence of disc herniation or significant degenerative change. (Ex. 39).

Dr. Carr subsequently reported to the insurer that claimant's "recent injury was an aggravation of his previous problem and relates back to his 6/28/89 injury." Carr also concluded, however, that there was no "objective evidence" that claimant's back condition had worsened. (Ex. 40). He then indicated that he did not consider sensory test results, reduced range of motion or reduced strength testing to constitute objective evidence to support a worsening. (Ex. 47-1).

We conclude that the test results obtained by Dr. Carr clearly fall under the definition of "objective findings" pursuant to ORS 656.005(19). We further conclude that Carr's findings are sufficient to constitute medical evidence of a compensable worsening of claimant's condition. Finally, Carr's opinion regarding what does and does not constitute such evidence is irrelevant to our decision. Craig H. Ayer, supra. We conclude that claimant's worsened condition was established with medical evidence supported by objective findings.

We further find that claimant's worsening resulted from his original injury, (Ex. 47-1, 48-1), and caused a diminishment in earning capacity. At the time of the March 1991 Determination Order, claimant had been released to light work. Following his May 1991 exacerbation, on the other hand, he was released from work altogether by Dr. Carr. Finally, there was no evidence that the March 1991 Determination Order contemplated waxing and waning of symptoms. (See Exs. 34, 35). Claimant proved a compensable aggravation.

Interim Compensation

A carrier is obligated to pay interim compensation on an aggravation claim beginning no later than 14 days after the carrier receives medical verification of the worker's inability to work due to the compensable condition. Payment is to continue until a formal denial of the claim is issued. ORS 656.262(4); Bono v. SAIF, 298 Or 405 (1984). Claimant asserts that, based on a May 22, 1991 chart note by Dr. Carr, he is entitled to interim compensation from that date until the insurer's June 26, 1991 denial letter.

We agree with the Referee that Dr. Carr failed to attribute claimant's symptoms to his compensable injury until a June 14, 1991 letter to the insurer. Although Dr. Carr's May 22, 1991 chart note contained findings that claimant was experiencing back symptoms, he explicitly stated he was "not sure whether [claimant] has ruptured a disc or merely aggravated a facet joint." (Ex. 38-1). A chart note of June 5, 1991 also indicated that Dr. Carr was not sure if claimant had sustained an aggravation, since it stated that an MRI would be ordered "to see if there has been any change since he is having a lot of leg discomfort. This would also help us solve the problem of material worsening." (Id. at 3).

We find no indication in the chart notes prior to June 14, 1991 that Dr. Carr attributed claimant's symptoms to his compensable injury. Therefore, claimant did not become entitled to interim compensation before June 14, 1991. Although the June 14, 1991 letter stated that claimant's "recent injury was an aggravation of his previous problem and relates back to his 6/28/89 injury", the insurer issued its denial on June 26, 1991, or within 14 days of Dr. Carr's letter. The insurer, therefore, was not obligated to pay claimant interim compensation.

Penalties and Attorney Fees

Finally, claimant asserts that the insurer's denial was unreasonable. A penalty may be assessed when a carrier unreasonably denies a claim. ORS 656.262(10). In order for a denial to be unreasonable, the carrier cannot have a legitimate doubt as to its liability. Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988).

The insurer asserts that because Dr. Carr stated in his June 14, 1991 letter that there were no objective findings to support a worsened condition, it had a legitimate doubt concerning its liability.

We first note that our order in Suzanne Robertson, supra, did not issue until June 27, 1991. The insurer, therefore, did not have benefit of this order on the date of its June 26, 1991 denial. In addition, in the June 14, 1991 letter, Dr. Carr stated that "though [claimant's] symptoms have worsened, there is

no objective evidence that his low back condition has worsened since 3/22/91." (Ex. 40). Under such circumstances, we conclude that the insurer was not unreasonable in relying on Dr. Carr's opinion concerning whether claimant's condition constituted a compensable aggravation. Therefore, we conclude that its denial was not unreasonable and there is no entitlement to a penalty.

Claimant's attorney, however, is entitled to an assessed attorney fee for finally prevailing against the insurer's denial of claimant's aggravation claim. 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 services at hearing and on review regarding the aggravation issue is \$3,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 15, 1992 is reversed in part and affirmed in part. That portion of the order upholding the insurer's denial of claimant's aggravation claim is reversed. The insurer's denial is set aside and the claim is remanded for processing. The remainder of the order is affirmed. For services at hearing and on review regarding the aggravation issue, claimant's attorney is awarded an assessed fee of \$3,000, to be paid by the insurer.

December 31, 1992

Cite as 44 Van Natta 2576 (1992)

In the Matter of the Compensation of
DUANE C. GAULT, Claimant
 WCB Case No. 91-01278
 ORDER ON REVIEW
 Malagon, et al., Claimant Attorneys
 Roberts, et al., Defense Attorneys

Reviewed by Board Members Kinsley and Brazeau.

The self-insured employer requests review of Referee Gruber'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 which declined to award him any unscheduled permanent disability for headaches caused by his compensable right eye injury. On review, the issues are rate of scheduled permanent disability and extent of unscheduled permanent disability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

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

The Referee declined to award claimant unscheduled permanent disability for his headaches, finding that the headaches did not limit repetitive use of a body part identified in the disability standards in effect on October 4, 1990, the date of the Determination Order. See former OAR 436-35-320(5) (WCD Admin. Order 7-1988, as amended by (Temp.) WCD Admin. Order 15-1990). We agree and affirm the Referee's order on this issue. See Joseph F. Prusaski, 44 Van Natta 2311 (1992).

Claimant contends, for the first time on Board review, that the Director should adopt a temporary rule to rate claimant's headaches because the standards are inadequate to address his disability, and requests that we remand this matter to the Director. See ORS 656.726(3)(f)(C). We find no evidence that during the reconsideration process claimant requested the Director to adopt a temporary rule addressing his disability. Id. Nor do we find evidence that claimant raised this argument before the Referee, or asked the Referee to remand this case to the Director for adoption of a temporary rule addressing his disability. Under such circumstances, we are not inclined to consider an issue raised at this late date. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991); Ronald L. Eagon, 44 Van Natta 2060 (1992). In any event, even if we did consider the issue, we have recently concluded that we lack the authority to take the action claimant is seeking. See Gary D. Gallino, 44 Van Natta 2506 (1992).

ORDER

The Referee's order dated April 24, 1992 is reversed in part and affirmed in part. That portion of the Referee's order which directed the self-insured employer to pay claimant's scheduled permanent disability award at the rate of \$305 per degree is reversed. The remainder of the Referee's order is affirmed.

December 31, 1992

Cite as 44 Van Natta 2577 (1992)

In the Matter of the Compensation of
MICHAEL D. GIBSON, Claimant
WCB Case No. 91-17942
ORDER ON REVIEW
Coons, et al., Claimant Attorneys
Nancy Marque (Saif), Defense Attorney

Reviewed by Board Members Kinsley and Brazeau.

Claimant requests review of Referee Baker's order that affirmed the Order on Reconsideration award of 2 percent (3 degrees) scheduled permanent disability for the loss of use or function of the left forearm (wrist) and 3 percent (4.5 degrees) scheduled permanent disability for the loss of use or function of the right forearm (wrist). On review, the issue is extent of scheduled permanent disability.

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

ORS 656.726(3)(f)(C) provides that when, upon reconsideration of a determination order, it is found that the worker's disability is not addressed by the standards for evaluating permanent disability, the Director shall stay further proceedings on the reconsideration of the claim and shall adopt temporary rules amending the standards to accommodate the worker's impairment.

There is no indication in this record that claimant requested the Director to adopt temporary rules to address claimant's alleged impairment due to loss of grip strength. Nevertheless, we have recently held that neither the Referee nor the Board has the authority to adopt temporary rules amending the standards or to remand this matter to the Director for the adoption of such rules. Gary D. Gallino, 44 Van Natta 2506 (1992). Therefore, when reviewing the Order on Reconsideration, our authority is limited to applying the standards adopted by the Director. Id.

ORDER

The Referee's order dated March 20, 1992 is affirmed.

In the Matter of the Compensation of
HARTMUT KARL, Claimant
WCB Case No. 91-14295
ORDER ON REVIEW
Bottini, et al., Claimant Attorneys
Williams, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Neidig.

Claimant requests review of Referee Leahy's order that: (1) upheld the insurer's denial of claimant's aggravation claim for a left knee condition; and (2) declined to award a penalty for an allegedly unreasonable denial. Claimant also moves to remand this case to the Referee for the admission of additional evidence. On review, the issues are remand, aggravation, 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.

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant moves to remand for the admission of evidence concerning claimant's termination from his job shortly after the issuance of the Referee's order. Claimant asserts that evidence of the termination constitutes a post-hearing admission by the employer that claimant was more disabled than at the last arrangement of compensation.

We may remand a case to the Referee for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5); Bailey v. SAIF, 296 Or 41 (1983). Evidence that a claimant has been terminated from a job post-hearing does not warrant remand; such evidence is not material to the claimant's condition at the relevant time for making our determination concerning its aggravation claim. See Cordero v. Moller's Nursery, 107 Or App 133, 135 (1991). Therefore, we deny claimant's motion to remand.

Aggravation

Claimant next contends that the insurer's denial was "unreasonable." From the context of claimant's assertion, we interpret this argument to be that claimant has proved a compensable claim for aggravation. We agree.

In order to establish a compensable aggravation, claimant must prove that his compensable condition has worsened since the last award or arrangement of compensation. See ORS 656.273(1). Because this claim concerns claimant's left knee, a scheduled body part, claimant must show an increased loss of use or function of that body part since the last arrangement of compensation. 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 for which permanent disability has been previously awarded, claimant must prove that the worsening constitutes more than waxing and waning of symptoms contemplated by the previous permanent disability award. ORS 656.273(8).

Claimant injured both knees during an April 1990 work incident. In an October 9, 1990 closing examination, Dr. Treible, an orthopedic surgeon and claimant's former treating physician, reported that despite surgery to the left knee, claimant continued to experience pain in his knee "after standing for a long period of time, working and twisting on his knees." He also suffered hypesthesia over the medial aspect of the left knee. (Ex. 21-1). Dr. Treible noted a range of motion in both knees of 5 to 125 degrees and reported that claimant could perform a deep knee squat without pain. (Id. at 21-2). Having previously released claimant to work without restrictions, Dr. Treible declared claimant medically stationary. (Id. at 3). Dr. Treible later reported "minimal" disability in claimant's left knee due to the persistent pain. (Ex. 24).

An October 26, 1990 Determination Order awarded 11 percent scheduled permanent disability for claimant's left knee. That award was reduced to 10 percent by a June 24, 1991 Order on Reconsideration.

On March 14, 1991, claimant sought treatment from Dr. Thompson, an orthopedic surgeon. Dr. Thompson noted that claimant continued to experience symptoms in his left knee "very similar to that which was present preoperatively." (Ex. 24AA-1). The report also found that claimant did not limp and could do a standing hop test without difficulty, but that he performed only 75 percent of a squat. (*Id.* at 2). Dr. Thompson recommended a bone scan to rule out osteonecrosis of the left knee. (*Id.*)

The bone scan did not specifically rule out osteonecrosis. (Ex. 25). Dr. Thompson, therefore, scheduled claimant for an MRI, which indicated "decreased signal compatible with ischemic necrosis." (Ex. 25A). Dr. Thompson then released claimant from work on the basis of "probable osteonecrosis," (Ex. 26), and recommended that claimant use crutches. (Ex. 28). Dr. Thompson opined that the cause of claimant's condition was the April 1990 injury. (Exs. 29, 32).

Claimant then underwent an independent medical examination with Dr. Hazel, also an orthopedic surgeon. Based on the most recent MRI, Dr. Hazel agreed with the diagnosis of osteonecrosis and also related it to claimant's April 1990 injury. (Ex. 30-3).

Dr. Thompson referred claimant to Dr. Colville, Assistant Professor of Orthopedics and Rehabilitation at OHSU. Colville ordered another MRI, which revealed no evidence of osteonecrosis. (Ex. 36). Dr. Colville reported that claimant "did have an involvement of the tibial plateau with a pathologic process" which had not been confirmed as being osteonecrosis. Colville suggested that the tibial plateau involvement was a response to trauma, considering the history of claimant's injury. Colville felt that there was a "high medical probability" that claimant's knee condition was traumatic in origin and that the April 1990 injury was the major contributing cause of claimant's knee problems: (Ex. 40). Dr. Colville's final report diagnosed "trauma to the medial tibial plateau secondary to impact injury," and stated that claimant would "have a permanent partial disability which will prevent him from heavy use of the knee" (Ex. 43).

Dr. Thompson subsequently reported that claimant's symptoms were more likely due to a bone bruise than osteonecrosis, but that in either event, the April 1990 event was the cause of claimant's condition. (Ex. 42A-1).

From the foregoing evidence, we find that although the precise diagnosis of claimant's condition remains uncertain, claimant's condition was caused by trauma to the left knee, and that the trauma arose, at least in material part, from the April 1990 injury.

The central dispute is whether or not claimant has proved a worsening of that condition. We conclude that claimant currently is more disabled than he was at the time of the last arrangement of compensation. Dr. Treible released claimant without any restrictions and during the closing examination, found that claimant continued to experience pain in his knee "after standing for a long period of time, working and twisting on his knees" and could perform a deep knee squat without evidence of pain behavior. Dr. Treible also reported "minimal" disability.

When claimant first saw Dr. Thompson, however, claimant could perform only 75 percent of a squat. Dr. Colville's final examination reported that claimant could walk "approximately two blocks" and then had to sit down due to "considerable pain in the knee." Furthermore, Dr. Colville concluded that claimant would permanently be restricted to light duty work, which did not include climbing, kneeling and heavy lifting. We find that this evidence not only demonstrates that claimant experienced more symptoms with less activity but that he could perform fewer activities due to his left knee condition. From this evidence, we conclude that claimant proved that he had greater loss of use or function of his left knee, as compared to the last arrangement of compensation. He, therefore, has proved a worsening of his compensable condition.

Finally, we note that the Referee found claimant's credibility to be questionable, primarily because of statements he allegedly made to coworkers about his game bird business. The Referee also found that claimant had "feigned a worsening" to his physicians.

We generally defer to the Referee's determination of credibility. See Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). In this case, however, we do not. Specifically, we note that both Dr. Thompson and Dr. Colville reported that claimant's game bird business did not contribute to his left knee

condition. Further, there was testimony that shortly before leaving work in March 1991, claimant asked for, but was denied, time off to move his game birds to another location. (Tr. 362).

We acknowledge the additional testimony that two days before leaving work, claimant informed the chairman of the company that he was moving his bird farm and had been offered a lucrative contract to sell a substantial number of game birds. (*Id.* at 342, 345). We conclude that this testimony, although of some weight, is not sufficient to defeat claimant's aggravation claim. First, there was no direct evidence to substantiate the rumor that claimant had moved his birds. Moreover, claimant testified that he did not move his business in March 1991, but rather sold and butchered his birds with the intent to leave the business. (Tr. 166). Finally, contrary to testimony that claimant simply did not return to work, claimant's personnel record shows that he worked until released by Dr. Thompson on March 28, 1991, except for those days when he had appointments with Dr. Thompson or underwent testing for his left knee. (*See* Exs. 45, 24A, 24AA, 26).

We are satisfied that claimant was essentially a credible witness, and we find that he has proved his claim for aggravation.

Penalties and Attorney Fees

Claimant also asserts that the insurer untimely processed his claim by denying it too late. Therefore, claimant contends that he is entitled to a penalty and attorney fee.

Under ORS 656.262(6), a carrier must accept or deny a claim within 90 days of notice of the claim. Claimant may make a claim for aggravation under ORS 656.273(2) or by submission of a physician's report under ORS 656.273(3). When proceeding under the latter provision, the physician's report must contain prima facie evidence in the form of objective findings that claimant's compensable condition has medically worsened. Herman M. Carlson, 43 Van Natta 963, 964 (1991), *aff'd* Carlson v. Valley Mechanical, 115 Or App 371 (1992).

On April 2, 1991, claimant's attorney sent a letter to the insurer, including Dr. Thompson's medical reports and release from work. (Ex. 27). In reviewing Dr. Thompson's reports dated prior to April 2, 1991, however, we fail to find prima facie evidence of a worsening. (*See* Exs. 24AA, 25, 26). Most notably, there is no evidence that claimant's working diagnosis at that time, osteonecrosis, was related to his compensable injury. Furthermore, there is no evidence that claimant's condition had resulted in a greater loss of use or function of his left knee. Consequently, we find that the April 2, 1991 submission did not constitute a claim for aggravation.

We conclude that the earliest report constituting a claim for aggravation is a July 8, 1991 report from Dr. Thompson to the insurer. In that report, Dr. Thompson related the diagnosis of osteonecrosis to the April 1990 injury, stated that claimant's game bird business was not a contributor, and found that claimant's previous permanent disability award was not adequate, thus indicating that claimant's left knee was more disabled. (Ex. 32). Therefore, we find that this report contained prima facie evidence of a worsening. However, because the insurer's denial issued within 90 days of this report, we conclude that the denial was timely. There is, therefore, no basis for a penalty or attorney fee.

Claimant is entitled to an assessed fee for services regarding the aggravation issue. *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 services at hearing and on review regarding this issue is \$3,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellant's brief), the complexity of the issue, and the value of the interest to claimant.

ORDER

The Referee's order dated January 31, 1992 is reversed. The insurer's denial is set aside and the matter is remanded for processing. For services at hearing and on review, claimant's attorney is awarded an assessed fee of \$3,500, to be paid by the insurer.

In the Matter of the Compensation of
JUANITA HOMEDEW-BURNS, Claimant
WCB Case No. 91-08179
ORDER ON REVIEW
Johnson, et al., Claimant Attorneys
VavRosky, et al., Defense Attorneys

Reviewed by Board Members Moller and Neidig.

The self-insured employer requests review of Referee Baker's order which set aside its partial denial of claimant's claim for her acute transverse myelitis condition. In its brief, the employer also contends that the Referee's attorney fee award was excessive. On review, the issues are compensability 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 concluded that claimant had established that her work injury was the major contributing cause of her acute transverse myelitis condition. We agree.

At hearing and on review, the parties both agree that claimant's myelitis condition claim is one for a consequential condition. After a review of the record, we agree that claimant is required to establish that her knee injury is the major contributing cause of her transverse myelitis. Albany General Hospital v. Gasperino, 113 Or App 411 (1992); ORS 656.005(7)(a)(A).

The employer argues that the Referee should not have accepted the expert opinion of Dr. Bourdette, M.D. The employer contends that Dr. Bourdette has conceded that trauma rarely causes acute transverse myelitis and that viral infection is a more likely cause of the condition. Dr. Bourdette also conceded that there was medical controversy concerning the causal relationship between trauma and a condition such as claimant's. Finally, the employer argues that the Referee should have relied upon the opinion of Dr. Englander, claimant's treating neurologist, or upon the opinion of Dr. Vesseley, an independent medical examiner.

We conclude that the fact that claimant's condition was caused in an unusual manner does not make Dr. Bourdette's opinion less persuasive. We find Dr. Bourdette's opinion to be candid, as he admitted that it was somewhat unusual for him to take such a position, but considering the facts of claimant's case, he believed that her condition was caused by the work trauma. Additionally, Dr. Bourdette based his opinion on not only a temporal relationship, but also on an anatomical relationship and reports of similar cases. (Ex. 35). Dr. Bourdette also considered the possibility of a viral infection, but explained why he ruled out such a cause in claimant's case. (Ex. 36).

We also disagree with the employer's contention that claimant's treating doctor has explicitly disagreed with Dr. Bourdette's opinion. On April 3, 1991, Dr. Englander noted that he had told claimant her myelitis episode was unlikely to be related to trauma, but he further added: "...although I could not exclude a relationship." (Ex. 16). Dr. Englander later reported that he believed that the type of trauma experienced by claimant would be "unlikely" to cause a myelitis. (Ex. 26-2). In evaluating Dr. Englander's opinion, however, we note that, following his reports, Dr. Englander referred claimant to Dr. Bourdette for evaluation. We find no subsequent agreement or disagreement by Dr. Englander with regard to the opinion of Dr. Bourdette.

Finally, we conclude that the Referee properly deferred to the opinion of Dr. Bourdette, who has expertise in the area of neurology, and specifically with myelitis and multiple sclerosis conditions. We find no reason to defer to the opinion of Dr. Vesseley, who apparently specializes in orthopedic surgery.

We conclude that Dr. Bourdette's opinion establishes that the work injury was the major cause of claimant's acute transverse myelitis. In arriving at our conclusion, we agree with claimant that,

although Dr. Bourdette has not used the word "major" to describe the contribution, his testimony supports such a finding. (Ex. 35-31, 35-34, 35-36). We, therefore, affirm the Referee on the issue of compensability.

Attorney fees/hearing level

On review, the employer argues for a reduction of the Referee's assessed attorney fee award of \$5,500. After reviewing the record, claimant's letter detailing the services provided, and the factors set forth in OAR 438-15-010(4), we find that an attorney fee of \$4,000 is a reasonable fee for claimant's counsel's services at hearing. Accordingly, we modify the Referee's attorney fee award.

Attorney fees/Board review

Claimant is entitled to an assessed attorney fee for prevailing over the employer's request for review on the issue of compensability. After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the issue of compensability 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 note that no attorney fee is available for that portion of claimant's brief devoted to the attorney fee issue. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The Referee's order dated May 29, 1992 is affirmed in part and modified in part. The Referee's attorney fee award of \$5,500 is modified. In lieu of the Referee's award, claimant is awarded \$4,000 for services at hearing, to be paid by the self-insured employer. The remainder of the Referee's order is affirmed. For services on review, claimant's counsel is awarded an attorney fee of \$1,000, to be paid by the employer.

December 31, 1992

Cite as 44 Van Natta 2582 (1992)

In the Matter of the Compensation of
DARREL L. HUNT, Claimant
WCB Case No. 91-11602
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Davis & Bostwick, Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The insurer requests review of that portion of Referee Podnar's order that found that claimant was permanently and totally disabled. In his brief, claimant contends that the Referee should have admitted exhibits that were submitted before the record closed but were not available at the time of hearing. On review, the issues are evidence and permanent total disability. We affirm.

FINDINGS OF FACT

We adopt the Referee's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

The Referee declined to admit Exhibits 78 and 79 into evidence, as he found that the record had been left open only to receive Dr. Misko's deposition. Exhibit 78 consists of a January 17, 1992 report authored by Dr. Flemming, to whom claimant was referred by Dr. Misko. Exhibit 79 is a February 28, 1992 letter from Dr. Misko.

On review, claimant argues that the exhibits constitute evidence regarding his motivation to return to work and should be admitted to rebut the testimony of Dr. Misko. Claimant further contends that the evidence was not available at the time of hearing.

A referee may continue a hearing upon a showing of due diligence if necessary to afford reasonable opportunity for the party bearing the burden to obtain and present final rebuttal evidence. See OAR 438-06-091(3); David F. Grant, 42 Van Natta 865 (1990). Further, OAR 438-06-091(3) is couched in permissive language and contemplates that the exercise of authority to continue a hearing rests within a referee's discretion. Sue Bellucci, 41 Van Natta 1890 (1989). Finally, ORS 656.283(7) provides that the referee is not bound by common law or statutory rules of evidence.

Here, we conclude that the Referee did not abuse his discretion by leaving open the record solely for the admission of Dr. Misko's deposition. Furthermore, we note that it was claimant who initially requested that the record be left open for receipt of the deposition. Under the circumstances, we do not find that the Referee abused his discretion by closing the record after Dr. Misko's deposition was received. See e.g. Richard D. Katzenbach, 44 Van Natta 299 (1992)(not an abuse of discretion by the Referee to allow further exhibits after a hearing where the record had not been left open solely for a deposition.)

Accordingly, in conducting our review, we do not consider those portions of claimant's brief that refer to evidence not admitted at hearing.

Permanent total disability

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

On review, the insurer contends that ORS 656.245(3)(b)(B) precludes the Referee from relying on any opinion other than that of the attending doctor in rating claimant's permanent disability. However, the statute provides, in part:

"Except as otherwise provided in this chapter, only the attending physician at the time of claim closure may make findings regarding the worker's impairment for the purpose of evaluating the worker's disability." (Emphasis added). ORS 656.245(3)(b)(B).

We have previously held that, with the exception of a medical arbiter appointed pursuant to ORS 656.268(7), only the attending physician may make impairment findings to be used in rating a claimant's disability. Dennis E. Connor, 43 Van Natta 2799 (1992). However, the "standards" provide no provision for rating permanent total disability, which requires a claimant to establish that he is unable to perform work at a gainful and suitable occupation, see ORS 656.206(1)(a); Wilson v. Weyerhaeuser, 30 Or App 403 (1977), rather than to prove entitlement to specific values and measureable impairment as defined by the standards. In this regard, we note that the rules providing for permanent total disability are found separately in Division 30 of the Department's rules, rather than in Division 35, which contain the standards. See OAR 436-30-055.

In the present case, the Referee found that the opinion of Dr. Misko, claimant's treating physician, was not persuasive because Dr. Misko recognized that claimant needed to be taken "off medications and to improve his situation so he can become employable," yet Dr. Misko continued to prescribe such medications and concluded that claimant was not permanently and totally disabled. Under the circumstances, we agree with the Referee that Dr. Misko's opinion is inconsistent and not persuasive.

Furthermore, we conclude that the Referee was entitled to rely upon the opinion of Dr. Gray, the consulting physician to whom claimant was referred by Dr. Misko. We conclude that Dr. Gray's opinion regarding claimant's permanent total disability status (which considered claimant's total condition, including the effects of the medications prescribed for the compensable condition), does not constitute "impairment findings" as described by ORS 656.245(3)(b)(B). Accordingly, although Dr. Gray is not claimant's attending physician, we agree that her opinion is persuasive and was properly used for purposes of determining whether claimant was permanently and totally disabled.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that \$1,000 is a reasonable assessed fee for claimant's counsel's effort on review. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue presented and the value of the interest involved. We

note that no attorney fee is available for those portions of claimant's respondent's brief devoted to the evidentiary issue.

ORDER

The Referee's order dated March 25, 1992 is affirmed. For services on review concerning the issue of permanent total disability, claimant's counsel is awarded an assessed attorney fee of \$1,000, to be paid by the insurer.

December 31, 1992

Cite as 44 Van Natta 2584 (1992)

In the Matter of the Compensation of
KARRI J. MANITSAS, Claimant
WCB Case No. 91-13173
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Garrett, et al., Defense Attorneys

Reviewed by Board Members Brazeau and Gunn.

Claimant requests review of Referee Nichols' order that concluded that the self-insured employer properly accepted claimant's deQuervain's disease as a aggravation of a 1988 compensable claim. Claimant contends that the condition is independently compensable as an occupational disease. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In this proceeding, claimant asserts a new occupational disease claim for deQuervain's disease. She contends that the condition was improperly accepted as an aggravation of her 1988 occupational disease claim for bilateral carpal tunnel syndrome, and relies on medical reports indicating that her need for treatment is unrelated to the previously accepted condition. The employer does not dispute compensability of the condition and concedes that deQuervain's disease is a separate diagnosable condition. It argues, however, that the condition is simply part of the larger overuse syndrome related to her prior claim and, consequently, is properly processed as such.

The employer specifically accepted only a claim for bilateral carpal tunnel syndrome. (Ex. 1C). The proper question, therefore, is whether claimant's deQuervain's disease is simply a worsening of her bilateral carpal tunnel syndrome, or whether it is, in fact, a separate and distinct condition that is independently compensable. We consider that question to be 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 were submitted in this matter. Claimant relies on the opinion of Dr. Strum, who opined that the condition was not related to the carpal tunnel syndrome, but rather represents a separate and distinct condition. The employer relies on the opinion of Dr. Stanford, who expressed the opinion that claimant's original bilateral carpal tunnel syndrome claim was the major contributing cause of her deQuervain's syndrome.

When there is a dispute between medical experts, we rely on those opinions that are both well-reasoned and based on complete information. Somers v. SAIE, 77 Or App 259 (1986). After our review of both opinions, we find that of Dr. Strum most persuasive. Although he incorrectly identified the date the deQuervain's disease was first diagnosed, we do not find such a minor error sufficient to invalidate his opinion. Moreover, his opinion is supported by a medical report submitted by Dr. Button, a hand surgeon, who determined in May 1990 that claimant's bilateral carpal tunnel syndrome had resolved and was asymptomatic. (Ex. 1F).

We give less weight to the opinion of Dr. Stanford because it is contrary to his earlier report, in which he opined that he was unable to determine whether claimant's deQuervain's syndrome was related to her original claim. (Ex. 4-4). Because Dr. Stanford failed to provide any explanation for his apparent change in opinion, we do not find his opinion persuasive.

Based on Dr. Strum's persuasive medical opinion, we conclude that claimant's deQuervain's disease of the right wrist is independently compensable as an occupational disease.

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 the compensability issue is \$3,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated April 10, 1992 is reversed. Claimant's new occupational disease claim for deQuervain's syndrome of the right wrist is remanded to the employer for acceptance and processing according to law. Claimant's attorney is awarded an assessed attorney fee of \$3,000 for services at hearing and on Board review, to be paid by the employer.

December 31, 1992

Cite as 44 Van Natta 2585 (1992)

In the Matter of the Compensation of
FAUSTINO MARTINEZ, Claimant
WCB Case No. 91-14810
ORDER ON REVIEW
Michael B. Dye, Claimant Attorneys
Julene Quinn (Saif), Defense Attorney

Reviewed by Board Members Westerland and Gunn.

Claimant requests review of those portions of Referee Schultz' order that: (1) upheld the SAIF Corporation's denials of claimant's cervical and lumbar spine injury claim; (2) declined to award additional interim compensation; (3) declined to assess penalties for an untimely denial of his lumbar spine injury; and (4) declined to assess penalties for alleged unreasonable denials of his cervical and lumbar spine injuries. In its brief on review, SAIF argues that the Referee erred in awarding claimant interim compensation from September 25, 1991 through October 23, 1991. On review, the issues are compensability, interim compensation, and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the Referee's findings of fact with the exception of his fourth ultimate finding of fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the Referee's reasoning and conclusions regarding: (1) the compensability of claimant's cervical and lumbar spine injury claim; and (2) the determination that SAIF's denials of this claim were not unreasonable.

Interim Compensation

The Referee found that SAIF was obligated to pay interim compensation benefits within 14 days of its receipt of a medical verification that claimant was off work due to a compensable injury. Under this rationale, he found that claimant was entitled to interim compensation benefits from September 25, 1991 through October 23, 1991, the date of SAIF's denial. We note that medical verification of an inability to work is not required in order to receive interim compensation for an initial injury. ORS

656.262; Shirley A. Bush, 43 Van Natta 59 (1991). However, on the facts of this case, we find that claimant is not entitled to interim compensation benefits.

"Interim compensation" is temporary disability payments made between the employer's notice of the injury and the acceptance or denial of the claim. Bono v. SAIF, 298 Or 405, 407 n. 1 (1984). A claimant's entitlement to interim compensation is triggered by the carrier's notice or knowledge of the claim. See ORS 656.262(4)(a); Stone v. SAIF, 57 Or App 808, 812 (1982). Although a claimant is entitled to interim compensation whether or not his or her claim eventually is proved compensable, there is no duty to pay such compensation if the worker has not left work pursuant to ORS 656.210(3). See Bono v. SAIF, *supra*, 298 Or at 408, 410. Furthermore, a claimant who is absent from work for reasons unrelated to the injury is not entitled to interim compensation. Nix v. SAIF, 80 Or App 656, 659 (1986).

Claimant argues that he was terminated on August 9, 1991 because he was unable to perform his job due to the alleged injury. Claimant relies on Shirley A. Bush, *supra*, to support his argument that he is entitled to interim compensation beginning August 20, 1991, the date the employer first had notice of his claim. We find Shirley A. Bush, *supra*, distinguishable on the facts. In Bush, the claimant established that she was terminated for reasons related to the condition that she subsequently claimed was compensable. Here, although claimant makes this same argument, he has not established the facts required to support his argument.

We agree with the Referee that claimant is not credible. On the other hand, the employer credibly testified that claimant was terminated for refusing to operate the equipment required to perform his job after he was reprimanded for being "too rough" on the equipment. The employer testified that claimant gave no reason for refusing to operate the equipment; instead, claimant walked away when asked for a reason. Furthermore, claimant continued working after the July 17, 1991 "bobcat" incident without any complaints of pain or pain behavior. He first sought medical treatment on August 15, 1991, almost a week after he was fired. On this evidence, claimant has not established that he was terminated for reasons related to the condition he subsequently claimed was compensable. Instead, we find that claimant was terminated for reasons unrelated to the alleged injury.

Because he did not "leave work" as that phrase is used in ORS 656.210(3), he is not entitled to interim compensation benefits. See Weyerhaeuser Co. v. Bergstrom, 77 Or App 425 (1986); Bono v. SAIF, *supra*. Accordingly, we reverse the Referee's award of interim compensation benefits. In addition, because claimant is not entitled to interim compensation benefits, it follows that SAIF did not act unreasonably in failing to pay those benefits. Therefore, we reverse the penalty assessed by the Referee for failure to pay interim compensation benefits.

Penalties on Late Denial of Lumbar Injury

We agree with the Referee's reasoning and conclusion regarding the fact that SAIF's delay in processing the lumbar injury claim was unreasonable.

However, a penalty is appropriately assessed for an unreasonable denial only if there are "amounts [of compensation] then due." ORS 656.262(10), 656.382; Wacker Siltronic Corporation v. Satcher, 91 Or App 654, 658 (1988). In the present case, claimant has not established a compensable injury and, based on our reasoning regarding the interim compensation issue, there are no amounts "then due." Consequently, a penalty may not be assessed.

ORDER

The Referee's order dated January 28, 1992, as reconsidered February 28, 1992, is affirmed in part and reversed in part. Those portions of the order that awarded interim compensation benefits (an attorney fee payable from this compensation) and penalties (1/2 to be shared by claimant's attorney) for failure to pay interim compensation benefits are reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
KEVIN C. O'BRIEN, Claimant
WCB Case Nos. 91-11524, 90-18071 & 91-09794
ORDER ON REVIEW
Welch, et al., Claimant Attorneys
Lundeen, et al., Defense Attorneys
Scheminske & Lyons, Defense Attorneys
Janice M. Pilkenton, Defense Attorney

Reviewed by Board Members Gunn and Brazeau.

Claimant requests review of Referee Davis' order that: (1) held that claimant had not requested a hearing concerning an August 5, 1991 denial of his February 1991 aggravation claim for a low back condition issued by Aetna Casualty & Surety Company; (2) upheld Aetna's July 26, 1990 denial of claimant's July 1990 aggravation claim for a low back condition; (3) upheld denials of claimant's aggravation claims for his low back condition issued by Liberty Northwest Insurance Corporation; (4) upheld Safeco Insurance Companies' denial of claimant's "new injury" claim for his low back condition; and (5) declined to assess penalties and attorney fees for allegedly unreasonable claim processing. On review, the issues are aggravation, compensability and responsibility. We affirm in part and reverse in part.

FINDINGS OF FACT

In December 1988, claimant sustained a low back injury while working for Liberty's insured. He sought treatment from Dr. Wagner, who diagnosed a low back strain and provided conservative treatment. Liberty accepted the claim and, on July 18, 1989, issued a Notice of Closure awarding benefits only for temporary disability.

In September 1989, claimant reinjured his low back while working construction for Aetna's insured. He returned to Dr. Wagner, who again provided conservative treatment. X-rays revealed a narrowing of the L4-5 and L5-S1 disc spaces with mild anterior osteophytes, as well as sclerotic changes in the facet joints at the lumbosacral level with occult spina bifida at S1. Aetna accepted the new injury claim and provided benefits. On March 20, 1990, a Determination Order issued awarding claimant benefits for temporary disability and 14 percent unscheduled permanent disability.

In July 1990, claimant experienced an increase in low back symptoms after working one day as a painter. He sought treatment from Dr. Lorish, who prescribed medication and referred claimant to a physical therapist. On July 26, 1990, Aetna issued a denial of an aggravation claim, asserting that claimant had sustained a new injury. Aetna did not contest compensability.

In August 1990, claimant began working in a print shop insured by Safeco. In January 1991, he experienced increased low back pain and right hip pain. He returned to Dr. Wagner, who referred him to Dr. Benz. A May 1991 MRI scan revealed degenerative disc disease at L4-5 and a small bulging disc centrally and to the right. It also revealed some intervertebral disc disease at L5-S1 with a small broadbase bulge.

On June 21, 1991, Safeco denied responsibility for claimant's current condition. On July 18, 1991, Liberty denied responsibility for claimant's current condition. On August 5, 1991, Aetna denied both compensability and responsibility for claimant's current condition. Claimant requested a hearing on those denials, as well as Aetna's July 26, 1990 aggravation denial, and a consolidated hearing was convened on October 21, 1991.

CONCLUSIONS OF LAW AND OPINION

The first issue presented is whether claimant sustained a compensable low back aggravation after working one day as a painter during the summer of 1990. The Referee concluded that he did not, finding no evidence that the symptomatic flare-up was greater than that anticipated by the last award of compensation. Accordingly, the Referee upheld Aetna's July 26, 1990 aggravation denial. After our review, we agree with the Referee's conclusion and adopt that portion of his order.

The next issue presented is which of three carriers is responsible for claimant's current low back condition. Applying ORS 656.308(1), the Referee found that the medical evidence placed responsibility with Aetna, the last carrier against whom claimant had an accepted low back injury claim. The Referee concluded, however, that claimant had failed to request a hearing on Aetna's August 5, 1991 denial until after the record had closed. Accordingly, the Referee upheld the respective denials of the other two insurers and referred the dispute concerning claimant's "post-record closure" hearing request of Aetna's denial to the Hearings Division for assignment of a new hearing date.

On review, claimant argues that he did request a hearing on Aetna's August 5, 1991 denial. He relies on an affidavit filed with the Hearings Division on August 15, 1991, which was submitted as part of a request for an expedited hearing and provided, in part:

"On February 1, 1991, I suffered an injury while employed at Pronto Print, through the Preferred Worker Program. Aetna, Liberty Northwest and Pronto Print's carrier Safeco have all denied responsibility for this injury. Additionally Aetna has denied the claim based on compensability." (Emphasis supplied).

Because only Aetna's August 5th denial denied compensability of the claim, claimant argues that the affidavit was a valid request for hearing on that denial. Aetna responds that the affidavit was deficient as a hearing request, because it only recites the fact that Aetna had denied the claim and fails to indicate that claimant intended to appeal the denial.

It is well understood that a claimant has an obligation to request a hearing in response to each denied claim. Naught v. Gamble, Inc., 87 Or App 145 (1987). The test for determining what constitutes a valid request for hearing, however, is less clear. ORS 656.283(3) sets forth several requirements:

"A request for hearing may be made by any writing, signed by or on behalf of the party and including the address of the party, requesting the hearing, stating that a hearing is desired, and mailed to the board."

The Court of Appeals has held, however, that a request for hearing need not meet all the literal requirements of that statute in order to entitle a claimant to a hearing. In Burkholder v. SAIF, 11 Or App 334 (1972), a claimant inadvertently mailed a request for hearing on a denial to the insurer. His attorney, however, later wrote a letter to the Board, stating: "Would you kindly advise me of [the] prospective date of hearing [in] the above captioned matter." Although the letter failed to provide the claimant's address, the court concluded that such a minor deviation was insufficient to defeat the claimant's right to a hearing, especially in light of the general policy that statutory requirements be construed liberally in favor of injured workers.

In Guerra v. SAIF, 111 Or App 579 (1992), the court recently held that a claimant's request for hearing incorrectly naming the insurer was not a proper request for a hearing on the insurer's compensability denial. In that case, the claimant injured her back at work and initially filed a claim against Liberty. The claimant's attorney, however, was later misinformed that Crawford was the employer's carrier and, consequently, requested a hearing only against Crawford. The court affirmed our conclusion that the claimant's request for hearing naming Crawford as the insurer was not an effective request for hearing from Liberty's denial. The court reasoned that the statutory framework evinced a legislative intent that a request for hearing be referable to a particular denial, and concluded that the provisions of ORS 656.283(3) provided the procedural framework to accomplish that objective.

After considering this matter in light of those cases, we conclude that claimant's affidavit and expedited hearing request, when read as a whole and in the context in which they were submitted, constitute an adequate request for hearing from Aetna's August 5th denial. Like the court in Burkholder, we do not consider the omission of claimant's address from those documents sufficient to defeat his right to a hearing. Moreover, unlike the facts in Guerra, we find the request for hearing clearly referable to the August 5th denial, because, as noted above, only that denial denied compensability of the claim.

We also find that the documents sufficiently evidence claimant's intent to challenge the denial. Although the affidavit fails to expressly request a hearing on the denial, we believe that his intentions to

do so are clear. Claimant's identification of Aetna's denial and his request for an expedited hearing on his claims logically leads to that conclusion. That conclusion is also supported by claimant's attorney's identification of issues at hearing, during which she first clarified that the hearing was a consolidated one involving a July 1990 aggravation and a February 1991 injury, and explained that, with regards to the second claim, all three carriers had denied responsibility, while Aetna had also denied compensability. (Tr. 6). Considering those statements in the context in which they were given, it is obvious that claimant was appealing Aetna's August 5, 1991 denial, and that claimant's attorney evidently believed that the August 15 affidavit and expedited hearing request had effectuated that appeal.

In reaching this decision, we note that, when asked if he would like to make an opening statement, Aetna's counsel said:

"Well, not really an opening statement. I just want to clarify the issues just a smidge. I understand that claimant has requested a hearing to challenge Aetna's denial of July 26, 1990, and Safeco's denial is--let's see here--yeah, Safeco's denial is dated 6-21-91, and Liberty denied on 8-16-91. I want to make sure that the records clear as to what denials have been challenged." (Tr. 8).

We understand that statement as an indirect attempt to raise the issue of whether claimant had, in fact, requested a hearing against Aetna's August 5, 1991 denial. We also acknowledge that claimant's former counsel did not contest or otherwise respond to Aetna's counsel's statement. Nonetheless, given the fact that claimant's counsel had already identified the issues as including Aetna's compensability denial of the February 1991 claim, we do not consider Aetna's counsel's statement sufficient to defeat claimant's entitlement to a hearing.

For the reasons given above, we conclude that claimant has requested a hearing against Aetna's August 5, 1991 denial. Moreover, after our review of the record, we agree and adopt the Referee's evaluation of the medical evidence and conclude that Aetna, as the last carrier against whom claimant had an accepted low back claim, remains responsible for his current low back condition. ORS 656.308(1); Donald C. Moon, 43 Van Natta 2595 (1991).

Claimant is entitled to an assessed attorney fee for prevailing against Aetna's August 5, 1991 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 and responsibility issue is \$4,000, to be paid by Aetna. 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.

Penalties

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

ORDER

The Referee's order dated February 14, 1992 is affirmed in part and reversed in part. Aetna's August 5, 1991 denial is set aside, and the claim is remanded to Aetna for further processing according to law. For services at hearing and on Board review for prevailing against the denial, claimant's attorney is awarded an assessed fee of \$4,000, to be paid by Aetna. The remainder of the order is affirmed.

In the Matter of the Compensation of
REBECCA L. RICHARDSON, Claimant
WCB Case Nos. 92-00728 & 92-00178
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
James Booth (Saif), Defense Attorney
Beers, et al, Defense Attorneys

Reviewed by Board Members Brazeau and Moller.

The SAIF Corporation requests review of Referee Myers' order that: (1) set aside its denial of claimant's occupational disease claim for her low back condition; and (2) upheld EBI Companies' denial of claimant's occupational disease claim for the same condition. In her brief, claimant contends that the Referee should have assessed penalties against both insurers for their allegedly unreasonable denials. On review, the issues are responsibility 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

Responsibility

We adopt the Referee's Conclusions of Law and Opinion, with the exception of the Referee's fourth paragraph in that section. We add the following supplementation.

On review, both SAIF and claimant argue that ORS 565.308 applies to this case. However, we have concluded that ORS 656.308 will not apply if the second injury (or occupational disease, in this case) does not involve the same condition as was previously accepted. ORS 656.308(1); see Beverly R. Tillery, 43 Van Natta 2470 (1991).

Here, claimant's prior accepted injury was to her neck and shoulder. However, the condition denied by both insurers involves her low back. Accordingly, we agree with the Referee's conclusion that the case is properly analyzed under the last injurious exposure rule. See Bracke v. Baza'r, 293 Or 239 (1982); Linda L. Wise, 42 Van Natta 115 (1990). We, therefore, adopt the remainder of his Conclusions of Law and Opinion on the responsibility issue.

Penalties

The Referee concluded that he could find no basis for assessment of a penalty against either insurer for an unreasonable denial. We agree that SAIF's denial, which denied responsibility only, was not unreasonable. However, we conclude that EBI's denial of both compensability and responsibility was unreasonable.

In SAIF v. Moyer, 63 Or App 498 (1983), the court found that the only medical evidence stated unequivocally that the claimant sustained an entirely new injury and not an aggravation. The court also found that no legitimate basis existed for contending that the claim was not compensable as to at least one of the insurers. Under those circumstances, the court concluded that the insurer's denial of compensability and refusal to request that the Department designate a paying agent was not reasonable and warranted imposition of penalties. Id. at 502.

On review, claimant argues that the facts of this case are identical to those in Moyer, supra. As noted above, we do not find SAIF's denial unreasonable, as it denied responsibility only. Consequently, the holding in Moyer does not apply to SAIF's conduct in this case. However, we agree with claimant that, because the only medical evidence in the record establishes that claimant's condition was the result of her cumulative years of employment as a checker, EBI's denial of compensability, which precluded claimant from obtaining a ".307" order, was unreasonable.

Accordingly, we assess a penalty against EBI in the amount of 25 percent of the temporary disability benefits which would have been due as of the date of hearing had a .307 order been issued. Consistent with Moyer, supra, we conclude that EBI may be assessed a penalty under such circumstances, even though SAIF has been ultimately found to be responsible for claimant's claim. Finally, claimant's attorney shall receive one-half the penalty in lieu of an attorney fee. ORS 656.262(10)(a); Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

Claimant's counsel is entitled to an assessed attorney fee, payable by SAIF, the insurer who requested Board review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that \$700 is a reasonable assessed fee for claimant's counsel's efforts on review concerning the issue of responsibility. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue presented, and the value of the interest involved. We note that no attorney fee is available for that portion of claimant's respondent's brief devoted to the penalty issue.

ORDER

The Referee's order dated March 24, 1992 is affirmed in part and reversed in part. That portion of the Referee's order that declined to assess a penalty against EBI Companies is reversed. EBI is ordered to pay claimant a penalty in the amount of 25 percent of the temporary disability benefits which would have been due as of the date of hearing had a .307 order been issued. One-half of the penalty is awarded to claimant's counsel in lieu of an attorney fee, also to be paid by EBI. For services on Board review, claimant's counsel is entitled to an assessed attorney fee of \$700, to be paid by the SAIF Corporation. The remainder of the Referee's order is affirmed.

December 31, 1992

Cite as 44 Van Natta 2591 (1992)

In the Matter of the Compensation of
MARLON H. SEWALL, Claimant
WCB Case No. 92-02547
ORDER ON REVIEW
Malagon, et al., Claimant Attorneys
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Gunn and Brazeau.

Claimant requests review of Referee Brown's order that upheld the self-insured employer's denial of claimant's ankle 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

The parties agree that compensability is appropriately analyzed under ORS 656.005(7)(a)(B). That statute provides that, when a compensable injury combines with a preexisting disease or condition, "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."

Claimant sustained a compensable sprain of the right ankle in September 1991. In November 1991, claimant's treating physician, Dr. Jones, orthopedic surgeon, reported that he had palpated a moveable mass over the ankle joint and, consequently, had diagnosed an "avulsed os fibularity." (Ex. 7). Dr. Jones recommended excision of the os fibularis and reattachment of the ligament. (Id.). A subsequent report indicated that, because claimant's condition was asymptomatic before the September 1991 injury, Jones had concluded that the os fibularity avulsed, or the cartilaginous bridge that attached to the os fibularity broke, as a result of the injury. (Ex. 10A).

Dr. Woolpert, orthopedic surgeon, conducted an independent evaluation. He had previously evaluated claimant in August 1990 and March 1991. Dr. Woolpert found that x-rays taken after the September 1991 injury, in comparison to those taken in September 1990, possibly indicated "some change of position of the os fibularis in the anterior views, but the foot itself is in a different position which may account for the change in appearance." (Ex. 9-3). Although Dr. Woolpert agreed that claimant showed a slight laxity in the right ankle, he was unable to detect any motion in the os fibularis. He concluded that, assuming that claimant had laxity in the ankle and that there was motion in the os fibularis, the condition was "chronic" and "more likely to be pre-existing." (*Id.* at 4). Dr. Woolpert disagreed that claimant had sustained a ligament tear and injury to the os fibularis because claimant's history after the September 1991 event was typical of a sprain and the most recent x-rays would have shown more changes. (*Id.*)

In a subsequent report, Dr. Woolpert reiterated his disagreement with Dr. Jones' opinion that claimant had sustained a torn ligament in September 1991, finding that the report from the emergency room, where claimant was initially evaluated following the accident, described symptoms typical of a sprain rather than a tear of the lateral ligament and loosening of the os calcis. (Ex. 11-2).

When the medical evidence is divided, we give greater weight to the opinion of the treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). Here, we conclude that Dr. Jones' opinion is not entitled to such deference. First, there is some question as to whether or not claimant has an avulsed os fibularity. Dr. Woolpert could not locate any movement in this area and he found that the x-rays only possibly supported such a diagnosis, and a CT scan of claimant's right ankle showed "no evidence of loose body or significant osseous abnormality." (Ex. 8-2). Furthermore, Dr. Jones' opinion is conclusory in comparison with Dr. Woolpert's opinion. Dr. Jones relies only on the fact that claimant was asymptomatic before the September 1991 event; he provides no explanation why claimant's initial history indicated only a sprain rather than a ligament tear, which, for Dr. Woolpert, was evidence that claimant's condition was preexisting.

Therefore, we find that Dr. Woolpert provided the more persuasive opinion. Based on his opinion, we conclude that claimant's os fibularity condition was not avulsed as a result of the September 1991 injury but rather preexisted that event. Consequently, we conclude that claimant failed to prove compensability of this condition under ORS 656.005(7)(a)(B). Inasmuch as we have found that the compensable injury had no effect on the os fibularity condition, we do not address claimant's contentions regarding *Barrett v. D & H Drywall*, 300 Or 325, *clarified* 300 Or 553 (1986).

ORDER

The Referee's order dated May 26, 1992 is affirmed.

December 31, 1992

Cite as 44 Van Natta 2592 (1992)

In the Matter of the Compensation of
MICHAEL J. SIMON, Claimant

WCB Case No. 91-07546

ORDER ON REVIEW

Royce, et al., Claimant Attorneys

Schwabe, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of Referee Barber's order that: (1) set aside its denial insofar as it denied that a low back injury occurred on December 10, 1990; and (2) declared moot the remaining portions of the denial which denied compensability of claimant's current condition. 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

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." ORS 656.005(7)(a)(B). 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.; Rita M. Parke, 44 Van Natta 1612 (1992).

Applying Bahman N. Nazari, supra, the Referee found that claimant proved that he injured his low back as a result of work activities on December 10, 1990. With the following supplementation, we adopt the Referee's reasoning and conclusions regarding the issue of the compensability of an initial injury. On December 12, 1990, claimant sought medical treatment from Dr. Flynn, treating physician, regarding the effects of the December 10, 1990 work incident. (Ex. 1-6). Dr. Flynn found that claimant had mild stiffness, loss of lumbar lordosis, and increased paraspinal spasm. Id. Dr. Flynn had been treating claimant for a noncompensable low back injury prior to the December 1990 work injury; thus, she is in the best position to determine the effects of any work injury. We find that Dr. Flynn's chart notes establish a need for medical services supported by objective findings. See Suzanne Robertson, 43 Van Natta 1505 (1991).

Dr. Flynn referred claimant to Dr. Weintraub, orthopedist, regarding the possibility of a disc problem and the need for an MRI. (Ex. 1-6). To support its argument that there was no compensable injury, the employer relies on the fact that Dr. Weintraub did not recommend any definite treatment. We disagree. As noted above, claimant sought medical treatment from Dr. Flynn, and her chart notes establish claimant's need for medical treatment regarding the work injury.

For the same reason, the employer's reliance on Theresa A. Snyder, 44 Van Natta 1191 (1992), is misplaced. In Theresa A. Snyder, the medical treatment following the work incident consisted solely of regularly scheduled, continuing treatments regarding a surgery previously performed for a preexisting condition. On that basis, we concluded that claimant failed to establish a compensable injury because the work incident required no medical treatment and produced no disability. Theresa A. Snyder, supra. Here, claimant required medical treatment from Dr. Flynn as a result of the work incident. Thus, for these reasons, as well as those cited by the Referee, we find that claimant has established a compensable low back injury as a result of his work activities on December 12, 1990.

However, the Referee also concluded that he could not proceed to the second step of the Nazari analysis because the insurer had not accepted the initial injury. Therefore, he declared moot that portion of the denial which denied compensability of the current condition. We disagree that the second step of the Nazari analysis, involving compensability of the resultant condition, cannot be addressed in this case.

The April 16, 1991 denial stated as follows:

"On December 10, 1990, you filed a claim for an industrial injury diagnosed as chronic episodic low back pain and herniated disc at L5-S1 allegedly sustained on or about December 10, 1990 while you were employed at Good Samaritan Hospital. According to evidence in our file, the incident of December 10, 1990 does not appear to be the major contributing cause of your current condition and need for treatment. Therefore, we must notify you that we will be unable to accept your claim." (emphasis added) (Ex. 11).

This denial was issued prior to our decision in Nazari, supra, which spelled out the two-step process discussed above. However, we find that this denial put at issue compensability of both the initial injury and the current condition and need for treatment. This denial was at issue at hearing. (Tr. 1). In addition, the record is fully developed in regard to both compensability issues. As discussed

above, claimant has established compensability of the initial injury. We proceed to discuss the merits of the compensability of claimant's current condition and need for treatment.

Claimant has a history of several incidents involving his low back prior to the work injury in December 1990. These incidents began in the summer of 1989. Two of these previous incidents occurred at work but claimant did not file workers' compensation claims on them. However, the most serious of these incidents occurred off the job in September 1990 while claimant was lifting 40 pound bales of straw. That injury resulted in claimant missing from three to four weeks of work. Claimant had never had an MRI prior to the December 1990 work injury. Following the work injury, claimant had an MRI which revealed a herniated L5-S1 disc.

Two physicians provide the only medical evidence regarding causation of claimant's current condition, which includes a herniated L5-S1 disc. Dr. Flynn, M.D., treated claimant for back problems both before and after the December 1990 work injury. She opined that an absent ankle jerk following the off the job low back injury in September 1990 "may have represented symptoms from a herniated disc." (Ex. 10). She also indicated that it was difficult to say with certainty whether claimant's employment at the insured was the major contributing cause of his current condition. (Ex. 10). However, she later concurred with a statement from a claims analyst that it was probable that claimant's herniated disc was due to the September 1990 injury rather than the December 1990 work incident. (Ex. 17). Dr. Flynn is in the best position to analyze the cause of claimant's current condition, having treated claimant for back problems both before and after the December 1990 work incident. However, the persuasiveness of her ultimate opinion is limited by the fact that it is no more than a check-the-box statement.

Dr. Flynn referred claimant to Dr. Weintraub, orthopedist, who opined that claimant had degenerative disc problems prior to the December 1990 work incident, and that claimant could have had an evolving herniated disc as far back as 1989. (Exs. 9, 14A, 15). Dr. Weintraub stated that he would not say that the December 1990 work incident was more than 50 percent responsible for claimant's back problems. (Ex. 14A). Instead, he stated that with claimant's "significant history of back trouble, a natural degenerative process is probably more than 50 percent responsible for his current condition and continued difficulty." (Ex. 14A).

Therefore, we conclude that claimant proved a compensable injury. However, on the basis of Dr. Weintraub's opinion, we find that the compensable injury combined with preexisting degenerative disk problems and 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 any future disability and/or need for treatment is related, in major part, to the compensable injury and is, therefore, compensable.

Finally, 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 low back injury is \$300, 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 statement of services), the complexity of the issue, and the value of the interest involved. We also considered the fact that claimant did not prevail on the issue of compensability of the resulting condition.

ORDER

The Referee's order dated March 20, 1992, as reconsidered on April 17, 1992, is affirmed in part and reversed in part. That portion of the order that held moot that portion of the self-insured employer's denial which denied claimant's current condition is reversed. The employer's denial of claimant's current low back condition is upheld. For services on review regarding the compensability of claimant's December 10, 1990 low back injury, claimant's attorney is awarded an assessed fee of \$300, to be paid by the employer. The remainder of the Referee's order is affirmed.

In the Matter of the Compensation of
SAURA C. STEWART, Claimant
WCB Case No. 91-13607
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Mitchell, et al., Defense Attorneys

Reviewed by Board Members Gunn and Westerband.

The self-insured employer requests review of Referee Hazelett's order that set aside a March 4, 1991 Determination Order as premature. On review, the issue is premature closure. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The Referee concluded that claimant's injury claim was prematurely closed, because the March 1991 Determination Order failed to consider claimant's injury-related psychological condition. We agree and adopt the Referee's conclusion. We add the following supplementation.

A claim for compensation shall not be closed if the worker's condition has not become medically stationary. ORS 656.268(1). The test for determining whether a worker is medically stationary is whether "further medical improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). A claimant's injury-produced psychological problems should be considered in determining whether the claim should be closed. Utrera v. Dept. of General Services, 89 Or App 114 (1987).

At the time of closure, March 4, 1991, all medical reports established that claimant was medically stationary from a physical standpoint. In January 1991, however, the Orthopaedic Consultants reported that claimant suffered from psychological factors affecting her recovery and recommended a psychological evaluation. Dr. Takla, claimant's treating physician, agreed with the report. While claimant's psychological condition was not diagnosed as major depression until after claim closure, we conclude that the pre-closure references to her psychological problems were sufficient to require the Evaluation Section to determine whether that condition was medically stationary prior to closing the claim. See Rogers v. Tri-Met, 75 Or App 470 (1985).

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 premature closure issue is \$850, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The Referee's order dated June 3, 1992 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of \$850, to be paid by the self-insured employer.

In the Matter of the Compensation of
JANCENE L. WALTHER, Claimant
WCB Case No. 91-10134
ORDER ON REVIEW
Karen M. Werner, Claimant Attorney
Bonnie V. Laux (Saif), Defense Attorney

Reviewed by Board Members Westerband and Gunn.

Claimant requests review of Referee Howell's order that affirmed an Order on Reconsideration which awarded no unscheduled permanent partial disability. In her brief, claimant argues that the Referee erred in refusing to admit proposed Exhibit 21, a post-Reconsideration Order medical report from claimant's attending physician. On review, the issues are extent of unscheduled permanent disability and evidence. We affirm.

FINDINGS OF FACT

We adopt the Referee's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

On review, claimant contends that the Referee erred in excluding proposed Exhibit 21, a post-Reconsideration Order medical report from claimant's treating physician. We disagree.

The extent of claimant's unscheduled disability is to be rated as of the date of the Order on Reconsideration. ORS 656.283(7). The March 12, 1992 medical report at issue pertains to claimant's condition several months after the October 24, 1991 Order on Reconsideration. Therefore, the proposed exhibit is not relevant to a rating of claimant's disability as of the time of the Order on Reconsideration. Teresa L. Erp, 44 Van Natta 1728 (1992). Moreover, we have previously held that medical evidence generated after the date of the Order on Reconsideration will not be considered pursuant to either ORS 656.268(5) or (7), in spite of the fact that such post-Reconsideration Order evidence comes from the attending physician. Nancy A. Worth, 44 Van Natta 2345 (1992).

Here, although proposed Exhibit 21 is from claimant's attending physician, it was generated well after issuance of the October 24, 1991 Order on Reconsideration. Accordingly, the Referee correctly declined to admit the disputed exhibit. Nancy A. Worth, *supra*.

Extent of Unscheduled Permanent Disability

The Referee found that since claimant did not raise the issue of the extent of unscheduled disability in her request for reconsideration to the evaluation section, that issue could not be raised at hearing. The Referee also noted that there was no evidence in the record of permanent injury-related impairment.

We affirm the Referee's decision on the basis that the record contains no medical evidence of permanent impairment. In this regard, the attending physician, Dr. Harada, found claimant medically stationary on July 23, 1991 with no ratable impairment. There is no other medical evidence of permanent impairment in the record as of claimant's medically stationary date. Therefore, no award of unscheduled permanent disability may be made. Former OAR 436-35-270(2). Inasmuch as we have found that no medical evidence of permanent impairment exists, we find it unnecessary to determine whether claimant may raise the issue of unscheduled disability when that issue was not raised in her request for reconsideration. Accordingly, the Referee's order is affirmed.

ORDER

The Referee's order dated April 10, 1992 is affirmed.

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Cite as 314 Or 291 (1992)

September 24, 1992

IN THE SUPREME COURT OF THE STATE OF OREGON

JAMES L. EDMUNSON, Petitioner on Review,

v.

DEPARTMENT OF INSURANCE AND FINANCE, Respondent on Review.
(CA A67544; SC S38858)

In Banc

On review from the Court of Appeals.*

Argued and submitted August 31, 1992.

Kevin N. Keaney, of Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland, argued the cause and filed the petition for petitioner on review.

Richard D. Wasserman, Assistant Attorney General, Salem, argued the cause and filed the response for respondent on review. With him on the response were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

GILLETTE, J.

The decision of the Court of Appeals is affirmed.

*Judicial review from the Department of Insurance and Finance. Court of Appeals' order of dismissal dated January 9, 1992.

314 Or 293> This is a proceeding under ORS 183.400¹ to determine the validity of two temporary rules adopted by the Workers' Compensation Division of the Department of Insurance and Finance (the Department). The Court of Appeals held that the challenged rule had been superseded by a later rule, and so declared the proceeding moot and dismissed it. We allowed review and now affirm the decision of the Court of Appeals.

The temporary rules challenged in this proceeding concerned disability rating standards for workers' compensation claims and were compiled in Oregon Administrative Rules (OAR) chapter 436,

¹ ORS 183.400 provides in part:

"(1) 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 which the validity of the rule may be determined by a court.

"* * * * *

"(4) The court shall declare the rule invalid only if it finds that the rule:

"(a) Violates constitutional provisions;

"(b) Exceeds the statutory authority of the agency; or

"(c) Was adopted without compliance with applicable rulemaking procedures."

division 35. They were adopted as "emergency" provisions² in two 1990 administrative orders <314 Or 293/294> of the Workers' Compensation Division of the Department and designated Administrative Orders (AOs) 15-1990 and 20-1990. AO 15-1990 was adopted September 14, 1990, and became effective October 1, 1990. AO 20-1990 was adopted November 20, 1990, and became effective immediately. Petitioner commenced the present proceeding on December 3, 1990. Petitioner claims that the Department, in adopting the temporary rules, failed to comply with the requirements of ORS 183.335(5)(a), (b), and (c), set out in note 2, *supra*.

By operation of law (ORS 183.335(6)(a)), both temporary rules had expired by May 19, 1991. Before either had expired, however, the Department adopted permanent rules, pursuant to ORS 183.335(1) to (4), including the following provisions (OAR 436-35-003(1) and (2)):

² Agency rules generally can be adopted only after notice and a right to be heard have been given to the general public. ORS 183.335(1) to (4). However, agencies are authorized to adopt temporary rules under certain circumstances:

"(5) Notwithstanding subsections (1) to (4) of this section, an agency may adopt, amend or suspend a rule without prior notice or hearing or upon any abbreviated notice and hearing that it finds practicable, if the agency prepares:

"(a) A statement of its findings that its failure to act promptly will result in serious prejudice to the public interest or the interest of the parties concerned and the specific reasons for its findings of prejudice;

"(b) A citation of the statutory or other legal authority relied upon and bearing upon the promulgation of the rule;

"(c) A statement of the need for the rule and a statement of how the rule is intended to meet the need; and

"(d) A list of the principal documents, reports or studies, if any, prepared by or relied upon by the agency in considering the need for and in preparing the rule, and a statement of the location at which those documents are available for public inspection.

"(6)(a) A rule adopted, amended or suspended under subsection (5) of this section is temporary and may be effective for a period of not longer than 180 days. The adoption of a rule under this subsection does not preclude the subsequent adoption of an identical rule under subsections (1) to (4) of this section.

"(b) A rule temporarily suspended shall regain effectiveness upon expiration of the temporary period of suspension unless the rule is repealed under subsections (1) to (4) of this section."

"(1) These rules apply to the rating of permanent disability pursuant to [ORS] chapter 656 and shall be applied to all claims closed on or after April 1, 1991, for workers medically stationary after July 1, 1990. For workers medically stationary prior to July 1, 1990, Administrative Order 6-1988 shall apply to the rating of permanent disability.

"(2) For claims in which the worker was medically stationary after July 1, 1990, the Appellate Unit shall apply the disability rating standards in effect on the date of issuance of the Determination Order or Notice of Closure." (Emphasis added.)

The Department moved to dismiss petitioner's rule challenge under ORS 183.400, arguing that, by its terms, the foregoing emphasized portion of the permanent rule independently dictates what rules shall apply to any claim that previously would have been governed by the temporary rules. Thus, the Department argued, the prior temporary rules had no continuing effect of their own, and any challenge to them <314 Or 294/295> was moot. The Court of Appeals agreed and dismissed the proceeding.

Before this court, petitioner presents the following argument: (1) The permanent rules purport to direct application of the same substantive legal standards that previously were made applicable to claims under the temporary rules -- that is the meaning and consequence of the use of the phrase "in effect" in permanent OAR 436-35-003(2). (2) But those temporary rules never were "in effect," because they were not validly adopted. (3) Thus, a challenge to the temporary rules has continuing validity to the extent that the outcome of the challenge will determine what set of rules is cross-referenced by the pivotal phrase in OAR 436-35-003(2).

That argument demonstrates its own error. Whatever is cross-referenced by the phrase, "in effect," in OAR 436-35-003(2), it is that cross-reference in the present rule that establishes the applicable law. That is, all claims are governed by the present permanent rule, not the former temporary ones. If there is an invalid or indeterminate cross-reference in the present rule, that is a problem with the present rule, not with any past rules. See *Mid-County Future Alternatives v. City of Portland*, 310 Or 152, 795 P2d 541 (1990) (challenge to municipal annexations was made on the ground that the annexations were invalid because the statutory scheme under which they were carried out was unconstitutional; challenge rendered void because legislature later and independently enacted same annexations).

The former temporary rules have now passed out of existence, and no one presently purports to be acting pursuant to any power originating in them. A challenge to those temporary rules is, therefore, moot. See *Hay v. Dept. of Transportation*, 301 Or 129, 719 P2d 860 (1986) (challenge to a rule that since had expired made challenge moot). The Court of Appeals was correct in so ruling.

The decision of the Court of Appeals is affirmed.

Cite as 314 Or 553 (1992)

November 5, 1992

IN THE SUPREME COURT OF THE STATE OF OREGON
In the Matter of the Compensation of Randy R. Westfall, Claimant.

RANDY R. WESTFALL, DAVID C. FORCE, Petitioner on Review,
v.
RUST INTERNATIONAL and UNDERWRITERS ADJUSTING COMPANY, Respondents
on Review.
(WCB 88-01147; CA A62442; SC S39025)

In Banc

On review from the Court of Appeals.*

Argued and submitted September 2, 1992.

David C. Force, of Vick & Gutzler, Salem, argued the cause and filed the petition in propria persona.

Darren L. Otto, of Scheminske & Lyons, Portland, argued the cause for respondents on review and filed a response.

James L. Edmunson, Eugene, argued the cause and David Gernant, Portland, filed a brief on behalf of amicus curiae Oregon Trial Lawyers Association.

GRABER, J.

The decision of the Court of Appeals is reversed. The case is remanded to the Court of Appeals with instructions to vacate the imposition of sanctions against claimant's lawyer.

*Petition for review of a sanction order in a judicial review from the Workers' Compensation Board. 111 Or App 289, 826 P2d 64 (1992).

314 Or 555> This case involves the interpretation and application of ORS 656.390, a provision of the Workers' Compensation Law providing for the imposition of sanctions against a lawyer who files a frivolous petition for judicial review or motion for reconsideration in connection with a workers' compensation claim.¹ We first set out the extensive procedural background of the case.

Claimant filed a petition for judicial review of an order of the Workers' Compensation Board (Board) denying compensation for a back injury. The Court of Appeals affirmed the Board's decision without opinion. *Westfall v. Rust International*, 102 Or App 373, 795 P2d 124 (1990) (*Westfall I*). The employer against whom the

¹ ORS 656.390 provides:

"Notwithstanding ORS 656.236, if either party appeals for review of the [workers' compensation] claim to the Court of Appeals or to the Supreme Court, or files a motion for reconsideration of the decision of the Court of Appeals or the Supreme Court, and the court finds that the appeal or motion for reconsideration was *frivolous* or was filed in *bad faith* or for the purpose of harassment, the court may impose an appropriate sanction upon the attorney who filed the appeal or motion. The sanction may include an order to pay to the other party the amount of the reasonable expenses incurred by reason of the appeal or motion, including a reasonable attorney fee." (Emphasis added.)

claim was made (employer) petitioned the Court of Appeals for sanctions against one of claimant's lawyers, on the ground that the petition for judicial review was frivolous within the meaning of ORS 656.390. The Court of Appeals granted the petition and imposed sanctions against the lawyer in the amount of employer's reasonable attorney fees. *Westfall v. Rust International*, 104 Or App 132, 798 P2d 1124 (1990) (*Westfall II*). The lawyer against whom the sanctions were imposed petitioned for reconsideration of the sanction order, arguing that he was not the lawyer who filed the original petition for judicial review of the denied claim. The Court of Appeals rejected that argument and affirmed the sanction order, reasoning that he had signed and filed a brief in the original petition for judicial review of the denied claim that was "wholly devoid of merit." *Westfall v. Rust International*, 107 Or App 395, 398, 812 P2d 31 (1991) (*Westfall III*).

The lawyer sought review in this court, which vacated the sanction order and remanded the case to the <314 Or 555/556> Court of Appeals for further consideration in the light of *Mattiza v. Foster*, 311 Or 1, 803 P2d 723 (1990). *Westfall v. Rust International*, 312 Or 34, 815 P2d 1272 (1991) (*Westfall IV*). In *Mattiza*, this court considered another sanctions statute, ORS 20.105(1),² and held that there were three prerequisites to an award of attorney fees under that statute: that the party seeking the award had prevailed in the relevant forum; that the claim, defense, or ground for appeal or review was meritless, that is, was "entirely devoid of factual or legal support"; and that the party against whom the sanction was sought had an improper purpose in bringing the claim, defense, or ground for appeal or review. *Mattiza v. Foster, supra*, 311 Or at 10. An improper purpose could be shown by evidence of actions taken in bad faith, wantonly, or solely for oppressive purposes; rarely, it could be inferred solely from the meritlessness of the claim. *Id.* at 9. Actions taken in bad faith were further construed as "conduct[] the primary aim of which was something other than the procurement of the fair adjudication of an authentic claim." *Id.* at 12.

On remand, the Court of Appeals concluded that the test for bad faith under ORS 20.105(1) had no bearing on a request for sanctions under ORS 656.390 for a "frivolous" appeal. *Westfall v. Rust International*, 111 Or App 289, 826 P2d 64 (1992) (*Westfall V*). Citing the disjunctive phrasing of ORS 656.390, the Court of Appeals held that sanctions may be ordered under that statute for a frivolous appeal even if that appeal was not filed in bad faith or for the purpose of harassment. 111 Or App at 292. Applying the *Mattiza* court's interpretation of the term "meritless" to the term "frivolous" in ORS 656.390, the Court of Appeals found that the

² ORS 20.105(1) provides:

"In any civil action, suit or other proceeding in a district court, a circuit court or the Oregon Tax Court, or in any civil appeal to or review by the Court of Appeals or Supreme Court, the court may, in its discretion, award reasonable attorney fees appropriate in the circumstances to a party against whom a claim, defense or ground for appeal or review is asserted, if that party is a prevailing party in the proceeding and to be paid by the party asserting the claim, defense or ground, upon a finding by the court that the party willfully disobeyed a court order or acted in bad faith, wantonly or solely for oppressive reasons."

petition for judicial review filed here was frivolous and affirmed the earlier sanction order. *Id.* at 293. We allowed review to address the interpretation of ORS 656.390.

314 Or 557> We agree with the Court of Appeals that there is no basis in the record for concluding that the petition for judicial review in this case was filed "in bad faith," ORS 656.390. *Westfall V, supra*, 111 Or App at 292. Neither is there a basis in the record for concluding that it was filed "for the purpose of harassment," ORS 656.390. Therefore, the first issue for us to consider is the meaning of the word "frivolous" in ORS 656.390.

In interpreting a statute, our task is to discern the intent of the legislature. ORS 174.020; *State ex rel Juv. Dept. v. Ashley*, 312 Or 169, 174, 818 P2d 1270 (1991). We begin with the text and context of the statute. ORS 174.010; *Porter v. Hill*, 314 Or 86, 838 P2d 45 (1992). When the text and context of the statute do not make the legislature's intention clear, we turn to legislative history to aid us in construing the statute. *Boone v. Wright*, 314 Or 135, 836 P2d 727 (1992).

ORS 656.390 was enacted in 1987. Or Laws 1987, ch 884, 31. The statute does not define "frivolous" or otherwise indicate what the legislature meant in using that word. The legislative history of the statute reveals that the provision was based on FRCP 11. Tape Recording, Senate Labor Committee, June 10, 1987, Tape 211, Side B. FRCP 11 states that a lawyer's signature on pleadings, motions, or other papers

"constitutes a certificate by the signer that the signer has read the pleading, motion, or other paper; that to the best of the signer's knowledge, information, and belief formed after reasonable inquiry it is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and that it is not interposed for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in cost of litigation."

Respecting FRCP 11, the court in *Eastway Const. Corp. v. City of New York*, 762 F2d 243, 253-254 (2d Cir 1985), *cert den* 484 US 918 (1987), stated:

"Prior to the 1983 amendment [to the rule], the rule spoke in plainly subjective terms: An attorney's certification of a pleading was an assertion that 'to the best of his knowledge, information, and belief, there [was] good ground to support it.' The rule, therefore, contemplated sanctions only where **<314 Or 557/558>** there was a showing of bad faith, and the only proper inquiry was the subjective belief of the attorney at the time the pleading was signed.

"The addition of the words 'formed after a reasonable inquiry' demand[s] that we revise our inquiry. No longer is it enough for an attorney to claim that he acted in good faith, or that he personally was unaware of the groundless nature of an argument or claim. * * * Simply put, subjective good faith no longer provides the safe harbor it once did.

"* * * * *

"* * * [W]e hold that a showing of subjective bad faith is no longer required to trigger the sanctions imposed by the rule. Rather, the sanctions shall be imposed against an attorney and/or his client when it appears that a pleading has been interposed for any improper purpose, or where, after reasonable inquiry, a competent attorney could not form a reasonable belief that the pleading is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification or reversal of existing law." (Citations omitted; footnote omitted; emphasis in original.)

See also *Business Guides v. Chromatic Com. Enterprises*, 892 F2d 802, 808 (9th Cir 1989) (federal circuit courts "have repeatedly emphasized that amended Rule 11 imposes an objective standard of conduct" (emphasis in original)), *aff'd* ___ US ___, 111 S Ct 992, 112 L Ed 2d 1140 (1991); *Aetna Life Ins. Co. v. Alla Medical Services, Inc.*, 855 F2d 1470, 1475-76 (9th Cir 1988) (lawyer can violate Rule 11 by filing "frivolous" paper even though not done for an improper purpose).

The Court of Appeals correctly concluded -- in reliance on interpretations of FRCP 11 -- that the imposition of sanctions under ORS 656.390 for a "frivolous" appeal does not depend on the subjective intent of the lawyer charged with filing the frivolous appeal. *Westfall V*, *supra*, 111 Or App at 292. However, the definition announced by the Court of Appeals in *Westfall V* is lacking in two respects. First, the court equated the term "meritless," which this court defined in *Mattiza v. Foster*, *supra*, with the term "frivolous" in ORS 656.390, even though the wording and structure of ORS 656.390 and ORS 20.105(1) differ considerably. See *ante* note 1 (quoting ORS 656.390) and note 2 (quoting ORS 20.105(1)). Second, the court's definition does not expressly allow for a <314 Or 558/559> good faith argument for the extension, modification, or reversal of existing law. We hold that an appeal is "frivolous" within the meaning of ORS 656.390 if every argument on appeal is one that a reasonable lawyer would know is not well grounded in fact, or that a reasonable lawyer would know is not warranted either by existing law or by a reasonable argument for the extension, modification, or reversal of existing law.³

Having established that standard, we turn to the question whether the arguments presented to the Court of Appeals in claimant's petition for judicial review of the Board's order permitted the court to find that the appeal was frivolous. *Westfall II*, *supra*, 104 Or App 132. That is, we ask whether every argument made by claimant's lawyer was one that a reasonable lawyer would know was not well grounded in fact, or that a reasonable lawyer would know was not warranted either by existing law or by a

³ Even though this test differs from the one announced in *Mattiza v. Foster*, 311 Or 1, 803 P2d 723 (1990), we note that a lawyer whose appeal is not "frivolous" within the meaning of ORS 656.390 also would not be subject to sanctions under ORS 20.105(1).

reasonable argument for the extension, modification, or reversal of existing law.⁴ Claimant's lawyer contends specifically that his argument is one that was warranted by a reasonable argument for the extension or modification of existing law. We begin our inquiry by summarizing the arguments made, and the facts and law relied on, by claimant's lawyer in his brief submitted to the Court of Appeals in *Westfall I*.

In January 1986, claimant suffered a low back strain during the course of his employment. He immediately sought and received treatment from a physician. Employer accepted the claim as a non-disabling injury. In July 1986, the treating physician declared that claimant was medically stationary without permanent impairment. Claimant requested continued treatment on the ground that his back continued to bother him, but employer denied that request.

Between July 1987 and December 1987, claimant sought and received treatment for additional symptoms of <314 Or 559/560> back pain. In December 1987, employer denied his claim for that treatment. Medical evidence was submitted to a referee by experts on both sides; claimant's experts attributed claimant's symptoms to the earlier compensable injury, while employer's experts attributed them to a congenital condition. In April 1988, the referee found that claimant had suffered no intervening injury that could have contributed to his additional symptoms and that claimant's testimony was credible. He also concluded that the issue whether the later symptoms were related to the compensable injury was "not a complicated case." The referee set aside the denial, and employer appealed to the Board.⁵

Pursuant to its authority under ORS 656.295, the Board reversed the referee's decision.⁶ Under the heading "CONCLUSIONS

⁴ When the Court of Appeals properly finds that an appeal is frivolous, then it has discretion whether to impose a sanction and, if so, to decide what sanction is appropriate. ORS 656.390.

⁵ ORS 656.289 provides in part:

"(1) Upon the conclusion of any hearing, * * * the referee shall * * * determine the matter and make an order in accordance with the referee's determination.

"* * * * *

"(3) The order is final unless, within 30 days * * *, one of the parties requests a review by the board under ORS 656.295."

⁶ ORS 656.295 provides in part:

"(5) The review by the board shall be based upon the record * * * and such oral or written argument as it may receive. * * * Any finding of fact regarding the worker's impairment must be established by medical evidence that is supported by objective findings. * * * However, if the board determines that a case has been improperly, incompletely or otherwise insufficiently developed or heard by the referee, it may remand the case to the referee for further evidence taking, correction or other necessary action.

"(6) The board may affirm, reverse, modify or supplement the order of the referee * * *.

"* * * * *

"(8) An order of the board is final unless within 30 days after the date of mailing of copies of such order to the parties, one of the parties appeals to the Court of Appeals for judicial review pursuant to ORS 656.298."

OF LAW," the Board stated that the case "present[ed] a complex medical question," that expert medical testimony therefore was relevant, and that the weight of such testimony, including evidence that claimant did not seek medical treatment between July 1986 and July 1987 and evidence that claimant had a pre-existing condition disposing him to back strain, supported a denial of his claim.

314 Or 561> In the brief supporting his petition for judicial review pursuant to ORS 656.298,⁷ claimant's lawyer presented the following questions:

"1. Is the issue whether an injured worker's low back strain has continued to produce symptoms over a period of time without intervening injury, a 'complex medical question' under the facts of this case?

"2. When the credible lay and expert testimony in a workers' compensation case is found by a Referee not to present a complex medical question, does the law compel the Board to reverse the Referee and reinstate a denial of medical care in an accepted claim because two members of the Workers' Compensation Board do not understand the facts as well as the Referee did?"

⁷ ORS 656.298 provides in part:

"(1) Any party affected by an order of the board may, within the time limit specified in ORS 656.295, request judicial review of the order by the Court of Appeals.

"* * * * *

"(6) The review by the Court of Appeals shall be on the entire record forwarded by the board. Review shall be as provided in ORS 183.482(7) and (8)."

ORS 183.482 provides in part: ^a

"(7) Review of a contested case shall be confined to the record, the court shall not substitute its judgment for that of the agency as to any issue of fact or agency discretion. * * *

"(8)(a) The court may affirm, reverse or remand the order. If the court finds the agency has erroneously interpreted a provision of law and that a correct interpretation compels a particular action, it shall:

"(A) Set aside or modify the order;

"(B) Remand the case to the agency for further action under a correct interpretation of the provision of law.

"* * * * *

"(c) The court shall set aside or remand the order if it finds that the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding."

As his only assignment of error, claimant's lawyer asserted:

"The Workers' Compensation Board erred in holding that Claimant's history of continuing symptoms while employed moving furniture for Rust International presented a 'complex medical question' which precluded a finding of compensability, based upon that history, as a matter of law."

314 Or 562> In the argument portion of the brief, claimant's lawyer pointed out that the Board had based its reversal of the referee's decision on its conclusion that the question of causation of claimant's back condition was a "complex medical question" and that resolution of the case therefore turned on the weight of medical opinion. He pointed out that the Board itself, citing *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 708 P2d 626 (1985), rev den 300 Or 546 (1986), had labeled that conclusion a "conclusion of law."⁸ In *Kassahn*, the Court of Appeals held:

"The Board may be persuaded by lay testimony on medical issues, but if the Board finds the lay testimony unpersuasive or insufficient to resolve complicated medical issues, it is not bound by that testimony and may require expert medical opinion to resolve the issue." 76 Or App at 109 (citation omitted).

Claimant's lawyer argued that the Board "did not find claimant's testimony unpersuasive" or "insufficient." He contended that the Board therefore erred in "interpreting ORS 656.295(5) and *Kassahn* to require expert medical analysis of the Claimant's credible testimony." Claimant's lawyer further argued that, because the Board's conclusion regarding claimant's symptoms was a conclusion of law, the Board was precluded from taking the action that it took. According to claimant's lawyer, although ORS 656.295(5) allows the Board to remand a case to the referee for the taking of further evidence if the Board determines that the record is "improperly, incompletely or insufficiently developed," it does not permit the Board simply to reverse a legal conclusion, such as the referee's "legal determination" that a case is "simple." He argued that the Board's error had the effect of altering claimant's burden of proof as to the causation of his injury. Finally, he argued that, where the Board has erroneously interpreted a provision of law, the Court of Appeals, pursuant to ORS 183.482(8)(a), should set aside or modify the Board's order, or remand it for further action under a correct interpretation of the law.

Employer countered that claimant's brief presented only a "factual dispute" disguised as an issue of law; that the **<314 Or 562/563>** Board's factual findings regarding claimant's medical condition were properly made under its power of *de novo* review; and that there was substantial evidence to uphold those findings. Employer also countered that claimant's argument regarding the burden of proof was "completely without merit" because, according

⁸ For the purposes of this case, we need not decide whether the Board's label was correct.

to decisions of this court, "in all but uncomplicated cases, claimant must carry his burden of proof by a preponderance of the evidence and must prove his case through the use of competent expert evidence." As noted above, the Court of Appeals affirmed the Board's decision without opinion, *Westfall I, supra*, and ordered sanctions against claimant's lawyer, on the grounds that there was "substantial evidence to support the Board's decision" and that the appeal was "frivolous." *Westfall II, supra*, 104 Or App at 133.

In *Uris v. Compensation Department*, 247 Or 420, 424, 426, 427 P2d 753, 430 P2d 861 (1967), this court held:

"It is, of course, the settled rule that

"' * * * where injuries complained of are of such character as to require skilled and professional persons to determine the cause and extent thereof, the question is one of science and must necessarily be determined by testimony of skilled, professional persons.' [Citations omitted.]

"* * * * *

"In the compensation cases holding medical testimony unnecessary to make a prima facie case of causation, the distinguishing features are an *uncomplicated situation*, the immediate appearance of symptoms, the prompt reporting of the occurrence by the workman to his superior and consultation with a physician, and the fact that the plaintiff was heretofore in good health and free from any disability of the kind involved. A further relevant factor is the absence of expert testimony that the alleged precipitating event could not have been the cause of the injury[.]" (Emphasis added; citation omitted.)

That principle was applied in *Pea v. Compensation Department*, 248 Or 487, 492-93, 435 P2d 821 (1967), where this court stated:

"It is apparent from the evidence presented by the plaintiff in this case, examined in light of the principles stated in <314 Or 563/564> *Uris v. Compensation Department, supra*, that no medical testimony is necessary * * *."

See also *Barrett v. Coast Range Plywood*, 294 Or 641, 645, 661 P2d 926 (1983) (in workers' compensation claim, whether rule regarding necessity for expert medical testimony is to be applied depends on whether medical question presented is "uncomplicated"); *Cleland v. Wilcox*, 273 Or 883, 543 P2d 1032 (1975) (where physician's evidence showed plaintiff's injury was not an "uncomplicated situation," rule stated in *Uris* required expert medical testimony); *Austin v. Sisters of Charity*, 256 Or 179, 183, 470 P2d 939 (1970) (where features of case met criteria set out in *Uris*, jury could decide causation of injury without expert testimony).

Claimant's argument centered on the meaning application of the term "uncomplicated" and related terms, as applied to the medical "situations" of workers' compensation claimants. The use of those

terms by referees and by the Workers' Compensation Board in the adjudication of workers' compensation claims is, arguably, sufficiently established to qualify those terms as "legal terms," and they appear to have been used as such by the parties here.⁹

314 Or 565> In his petition for judicial review of the Board's decision to the Court of Appeals, claimant's lawyer conceded that, "on judicial review pursuant to ORS 656.298, the Court [of Appeals] will not disturb the Board's weighing of competing medical opinions in the record." However, he also argued that, under that statute, "the Legislature has not prohibited the Court from reviewing the Board's applications of 'provisions of law.'" We conclude that the meaning of the terms used in *Uris v. Compensation Department*, *supra*, as well as the application of those terms to the facts of a particular worker's medical situation, arguably are questions of law that are reviewable by the Court of Appeals under ORS 656.298(6) and 183.482(8)(a). Claimant's lawyer's argument to that effect was not one that a reasonable lawyer would know was not warranted by a reasonable argument for the extension or modification of existing law. Therefore, the appeal was not "frivolous" within the meaning of ORS 656.390.

The decision of the Court of Appeals is reversed. The case is remanded to the Court of Appeals with instructions to vacate the order imposing sanctions against claimant's lawyer.

⁹ Here, the issue for claimant was the meaning and application of dispositive terms used in a decision of this court, *Uris v. Compensation Department*, *supra*, and its progeny. An analogous situation is presented when the meaning and application of a statutory term are at issue. That the application of a statute requires an examination of the facts and circumstances presented to the court does not make the matter a "question of fact" in all cases. *Can-Key v. Industrial Leasing*, 286 Or 173, 183, 593 P2d 1125 (1979). In *McPherson v. Employment Division*, 285 Or 541, 547-48, 591 P2d 1381 (1979), this court stated:

"The identification of errors of fact and errors of law for purposes of the scope of review * * * when an agency applies a broad statutory term to a particular situation, is one of the most problematic issues in administrative law. Agency decisions interpreting a legal term in applying it to particular facts are sometimes said to pose a 'mixed question of law and fact.' * * *

"'Facts' * * * are those elements entering into the decision that describe phenomena and events without reference to their significance under the law in question, or to put it another way, as they might be described by a lay person unaware of the disputed legal issue." (Citations omitted.)

The issue in *McPherson* was the meaning and application of the term "good cause" as used in a provision of the unemployment statute. The court held that the meaning and application of the term were "plainly [questions] of law." *Id.* at 548. See also *Kirkpatrick v. Peet*, 247 Or 204, 211, 428 P2d 405 (1967) (question whether certain facts are sufficient to support an administrative finding that a certain legal relationship exists is a question of law for the court to decide).

Cite as 115 Or App 236 (1992)

September 16, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON

LARRY J. GLUBKA, a chiropractic physician, Appellant,

v.

STANTON LONG and STATE ACCIDENT INSURANCE FUND (SAIF), Respondents.
(90C-12098; CA A69600)

Appeal from Circuit Court, Marion County.

Greg West, Judge.

Argued and submitted April 23, 1992.

Anthony A. Allen, Salem, argued the cause for appellant. With him on the brief were Daniel J. Gatti and Gatti, Gatti, Maier & Associates, Salem.

Don H. Marmaduke, Portland, argued the cause for respondents. With him on the brief were Nancy J. Moriarty and Tonkon, Torp, Galen, Marmaduke & Booth, Portland.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

ROSSMAN, J.

Reversed and remanded.

115 Or App 238 > Plaintiff appeals a judgment dismissing his amended complaint for failure to state ultimate facts sufficient to constitute a claim. ORCP 21A(8). We reverse.

Plaintiff is a licensed chiropractic physician whose practice includes treating injured workers. Some of the workers' employers are insured by defendant SAIF.¹ Plaintiff alleges that, in 1989, defendants initiated "Operation Clean Sweep," an investigation that involved the use of undercover operatives who presented themselves to plaintiff and other Oregon chiropractors, complained of injuries from which they were not suffering and received treatments. Apparently on the basis of evidence gathered during the investigation, defendants filed a racketeering and fraud action against plaintiff for charging SAIF higher fees than he charged the general public. That litigation has not yet concluded.

Plaintiff brought this action for tortious interference with contractual and prospective economic relations. Defendants moved to dismiss the amended complaint for, among other things, failing to state a claim. The trial court granted the motion on that ground and entered a judgment dismissing the action with prejudice. For the purpose of determining whether a complaint states a claim for relief, we consider as true the facts alleged and all reasonable inferences that may be drawn therefrom. *Gruner v. Lane County*, 96 Or App 694, 696, 733 P2d 815 (1989); *Emmert v. O'Brien*, 72 Or App 752, 754, 697 P2d 222 (1985); see also *Erickson v. Christenson*, 99 Or App 104, 106, 781 P2d 383 (1989).

Plaintiff's amended complaint alleges that (1) defendants had knowledge of the contractual and economic relationships between plaintiff and his patients; (2) defendants intended to interfere with those relationships by engaging in improper conduct with improper motives; (3) the improper conduct involved (a) implementing "Operation Clean Sweep," which involved falsifying medical and insurance records and reports and making fraudulent statements,² <115 Or App 238/239> (b) filing a racketeering and fraud action against plaintiff, knowing that "such labels were wrongful" and "intend[ing] to prejudice the Plaintiff with irreparable harm," and (c) coordinating a "media event" in which defendants defamed plaintiff by announcing their unfounded litigation against him, "so the Plaintiff and others would be held up to public contempt and ridicule"; (4) the improper motives were to discredit chiropractors, to enhance the reputation and image of the Attorney General, to convince a special session of the Oregon legislature to pass workers' compensation reform legislation and to protect SAIF from being liquidated

¹ SAIF is an independent public corporation providing workers' compensation insurance to Oregon employers. ORS 656.751(1); ORS 656.752. Long is the former Executive Director of SAIF Corporation.

² Plaintiff alleges that defendants violated various statutes by making false statements, falsifying business records, abusing public office, committing election law offenses and misrepresenting plaintiff's financial condition and conduct.

by the legislature in any upcoming session; (5) the conduct was intended to stop or limit plaintiff's practice by inducing patients to forego or limit further treatment; and (6) as a result of defendants' conduct, plaintiff has suffered non-economic and economic damages, including lost income and impairment of future income capacity.

To state a claim for intentional interference with economic and contractual relations, a plaintiff must allege that the defendant had knowledge of the plaintiff's contractual relationship and that the defendant's interference with those relationships was intentional. *Willamette Quarries, Inc. v. Wodtli*, 308 Or 406, 781 P2d 1196 (1989). The complaint also must allege "either the pursuit of an improper objective of harming plaintiff or the use of wrongful means that in fact cause injury to plaintiff's contractual or business relationship." *Lewis v. Oregon Beauty Supply Co.*, 302 Or 616, 621, 733 P2d 420 (1987); *Sheets v. Knight*, 308 Or 220, 237, 779 P2d 1000 (1989); see also *Top Service Body Shop v. Allstate Ins. Co.*, 283 Or 201, 205, 582 P2d 1365 (1978); *Johnson v. Oregon Dept. of Fish and Wildlife*, 114 Or App 335, 835 P2d 133 (1992). Given the benefit of all reasonable inferences, the complaint in this case alleges each of those elements and successfully states a claim for intentional interference with contractual relations.

Defendants argue that plaintiff's claim is only masquerading as an action for intentional interference and that it is actually a claim for wrongful initiation of civil proceedings. <115 Or App 239/240> They also argue that plaintiff has failed to allege facts sufficient to state the latter claim, because he has not prevailed in the pending action against him. See *Erlandson v. Pullen*, 45 Or App 467, 470-71, 608 P2d 1169 (1989). Having determined that plaintiff has stated a claim for intentional interference with contractual relations, we need not decide the question of whether he failed to state a different claim.

Defendants also contend that plaintiff's action improperly seeks to litigate the same question that is presented by their ongoing fraud and racketeering action against him. However, they overlook the fact that the appropriate method by which to address their concern is a motion to stay this proceeding. Without more, the mere existence of another proceeding is not a basis for dismissing a complaint with prejudice for failing to state a claim.

Finally, defendants assert that, as executive and administrative officials carrying out their official functions, their conduct was absolutely privileged. See *Beason v. Harcleroad*, 105 Or App 376, 385, 805 P2d 700 (1991); *Schroeder v. Poage*, 75 Or App 671, 675, 707 P2d 1240 (1985). They also contend that their actions involved policy judgments and that they are therefore protected by discretionary immunity. See *Lowrimore v. Dimmett*, 310 Or 291, 297 P2d 1027 (1990). Regardless of the merits of those arguments, at this stage of the proceedings no answer to plaintiff's complaint has been filed, no affirmative defense has been raised and our review is limited to the facts stated in the complaint. *Dell v. K.E. McKay's Market*, 273 Or 752, 759, 543 P2d 678 (1975); *Speer & Sons Nursery v. Duyck*, 92 Or App 674, 676, 759 P2d 1133 (1988). Plaintiff's complaint does not allege facts that establish as a matter of law that defendants' coordination of the undercover operation was absolutely privileged or entitled to discretionary immunity. Therefore, defendants' arguments present hypothetical questions that cannot be resolved on this record and cannot serve as a basis for dismissing plaintiff's claim.

Reversed and remanded.

Cite as 115 Or App 241 (1992)

September 16, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Clairrean Boyd, Claimant.

CLAIRREAN BOYD, Petitioner,

v.

SAIF CORPORATION and DISCOVERY PLASTICS, Respondents.
(WCB 89-16057; CA A68060)

In banc

Judicial Review from Workers' Compensation Board.

Argued and submitted July 1, 1991; resubmitted in banc August 5, 1992.

Roger Ousey, Eugene, argued the cause for petitioner. With him on the brief were Michael Strooband and Bischoff & Strooband, P.C., Eugene.

John T. Bagg, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmyer, Attorney General, and Virginia L. Linder, Solicitor General, Salem. DEITS, J.

Reversed and remanded.

Richardson, J., dissenting.

115 Or App 243 > Claimant seeks review of an order of the Workers' Compensation Board finding that her injury was not compensable. The Board adopted the referee's opinion. We reverse and remand.

After leaving work at the end of her shift, claimant went to her car, which was parked in employer's parking lot adjacent to claimant's work place. The parking lot was provided for employees, and claimant had been instructed to park there. When she started to get into her car, her knee twisted, she heard a popping noise and experienced immediate pain. She has had surgery and suffers some permanent impairment.

Claimant filed a claim on two bases: First, her disability was an occupational disease caused by the repetitive pivoting from side to side required by her job as a fabricator; and second, the twisting of her knee in the parking lot was an injury that occurred in the course and scope of her employment. SAIF denied the claim on both theories, and the Board upheld SAIF's denials.

The Board rejected the occupational disease claim on the basis of a medical opinion. Claimant contends that the Board's conclusion is not supported by substantial evidence. There were conflicting medical opinions about the genesis of claimant's disability, and the Board's selection of one as opposed to the other was not error. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 752 P2d 312 (1988).

Claimant's second assignment of error is that the Board erred in concluding that her injury was not sufficiently work related to be compensable. The Board adopted the referee's order, which said:

"I find the only connection between the injury and claimant's work was that the injury happened on the employer's parking lot. I do not find that to be sufficiently connected to claimant's work that it should be compensable under the statute."

Oregon follows the "going and coming rule" or limitation, which provides that injuries sustained while going to and from work are not compensable. *Cope v. West American <115 Or App 243/244> Ins. Co.*, 309 Or 232, 237, 785 P2d 1050 (1990). However, as noted by the court in *Cope*, one of the exceptions to the rule is when the injury occurs on the employer's premises, including an employee parking lot. 309 Or at 238.

"Oregon cases have uniformly held that injuries that occur in parking lots that are owned or maintained by the employer arise out of and in the course of employment and are compensable. If the injury occurs in a parking lot or other off-premises area over which the employer has no control, it is generally not compensable." *Montgomery Ward v. Cutter*, 64 Or App 759, 762, 669 P2d 1181 (1983). (Citations omitted.)

SAIF argues that because claimant was injured while getting into her car, as opposed to being injured while crossing the lot, or tripping over something in the lot, her injury is not sufficiently work related to be compensable. However, as explained in *Cope*, employer control of the property is the rationale supporting the parking lot exception. The fact that an injury occurs on employer-controlled premises while the employee is traveling to and from work makes the incident sufficiently work connected.

"[W]hen an employee *traveling to or from work* sustains an injury on or near the employer's premises, there is a 'sufficient work relationship' between the injury and the employment only if the employer exercises some 'control' over the place where the injury is sustained. Whether the requisite control is evinced by increased, employer-created hazards * * * or by the employer's property rights to be the area where the injury is sustained * * * is immaterial. *Some form of employer control of the area demonstrates the work-connection necessary to make the injury compensable.*" *Cope v. West American Ins. Co.*, *supra*, 309 Or at 239. (Emphasis supplied; citations omitted.)

In this case, employer's control over the parking lot, its instructions to its employees to park there and the fact that claimant was on her way home from work establish the work-connection. See *Liberty Northwest Insurance Corp. v. Rodriguez*, 97 Or App 500, 776 P2d 588 (1989). We recognize that not all injuries that occur on employer premises are necessarily work-connected and, therefore, compensable. Circumstances may show that the work-connection has been broken. If it is shown that a claimant was engaged in activity <115 Or App 244/245> of a personal nature, the injury may not be sufficiently work-connected. For example, in *Albee v. SAIF*, 45 Or App 1027, 1030, 609 P2d 920 (1980), we held that a claimant who slipped and fell while putting chains on his tires, even though he was in his employer's parking lot, was acting outside the course and scope of employment, because he had left work for the day and was putting chains on for personal benefit. Here, claimant's act of getting into her car at the end of her work shift was not of such a personal nature as to break the work-connection. We conclude that the Board erred in denying the compensability of claimant's injury on the basis that it was not within the course and scope of her employment.

Reversed and remanded.

RICHARDSON, J., dissenting.

I agree with the majority that the Board properly rejected claimant's occupational disease claim. Contrary to the majority, I think that the Board also properly rejected her injury claim.

The majority says:

"[A]s explained in *Cope [v. West American Ins. Co.]*, 309 Or 232, 785 P2d 1050 (1990)], employer control of the property is the rationale supporting the parking lot exception. The fact that an injury occurs on employer controlled premises while the employee is traveling to and from work makes the incident sufficiently work connected." 115 Or App at 244.

There is language in *Cope* to support that conclusion. However, the Supreme Court's statement of the rule must be evaluated in the light of the facts and the ultimate holding. The plaintiff worked for a lumber company and was allowed to park her car in the employee parking lot owned by her employer. The lot was across a public street from her workplace. She parked her vehicle in the lot and began walking across the parking lot to her workplace. Near the edge of the lot, bordered by a public sidewalk, she was struck by another employee's car and injured. She eventually sought underinsured benefits from her liability carrier, the defendant. Those benefits were not available to her if her injury was compensable under the Worker's Compensation Act. The pivotal inquiry was whether she was injured on the parking lot and, if <115 Or App 245/246> not, whether her injuries were nevertheless compensable because she was on her way to work.

The court discussed, at length, the "parking lot" exception to the "going and coming" limitation on workers' compensation coverage.¹ The majority has extracted some of the statements that the court made. The Supreme Court seems to have concluded that, if the employer controlled the parking lot where the employee was injured while in transit to or from work, that was a sufficient work connection for compensability. However, I doubt that, by that statement, the court intended to foreclose other traditional inquiries about whether the injury arose out of and in the course of employment. *Phil A. Livesley v. Russ*, 296 Or 25, 672 P2d 337 (1983); *Benefiel v. Waremart, Inc.*, 112 Or App 480, 829 P2d 736, rev den 313 Or 627 (1992). That the employer controls the parking lot, in essence, makes the lot part of the employer's premises, but the fact that the injury occurred on the premises does not necessarily mean that it arose out of and in the course of employment. In other words, the injury must have some connection with the work, not just the workplace.

For example, in *Otto v. Moak Chevrolet*, 36 Or App 149, 583 P2d 594 (1978), rev den 285 Or 319 (1979), we concluded that the claimant's injury was not compensable. The parties stipulated the facts:

"The injury occurred when claimant went to the women's restroom on the employer's premises, relieved herself and, while she was pulling her [underwear and slacks] back up in an ordinary manner, her back went out, i.e., she was suddenly afflicted with pain in the low back * * *." 36 Or App at 151. (Brackets in original.)

We held that the injury did not arise out of any risk of the claimant's employment.

In *Allbee v. SAIF*, 45 Or App 1027, 609 P2d 920 (1980), the claimant fell on the ice and was injured in the employer's parking lot while getting tire chains on his car. We <115 Or App 246/247> held that, even if he fell in the parking lot, his injury was not compensable, because he had left work and was on a personal mission. Consequently, the injury did not arise out of the employment.

The majority distinguishes *Allbee* by noting that the claimant there "was acting outside the course and scope of employment, because he had left work for the day and was putting chains on [his car] for personal benefit." 115 Or App at 245. Here, the majority finds, the claimant's "act of getting into her car at the end of her work shift was not of such a personal nature as to break the work-connection." 115 Or App at 245. I fail to see the difference between walking across an icy parking lot to get chains put on a car and getting into a car to go home. The only work connection of claimant's injury is that it occurred on a parking lot controlled by her employer. She had left work for the day and was on her way home, and no hazard of the parking lot or a risk of employment precipitated the injury. Her knee twisted and popped as she got into her car. I dissent.

Joseph, C.J., and Warren and De Muniz, JJ., join in this dissent.

¹ The dispositional holding was that there was an issue of fact as to whether plaintiff was on the parking lot or the public sidewalk when she was injured and so the summary judgment was in error. The court did not have to decide whether, if the plaintiff was injured on the parking lot, the injury also arose out of her employment.

Cite as 115 Or App 248 (1992)

September 16, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Karolyn K. Teresi, Claimant.

DENNIS UNIFORM MANUFACTURING and UNITED PACIFIC INSURANCE COMPANY, Petitioners,
v.
KAROLYN K. TERESI, SAFECO INSURANCE COMPANY, LIBERTY NORTHWEST INSURANCE CORPORATION, and WESTERN EMPLOYERS INSURANCE, Respondents.
(88-20424; CA A70483)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 12, 1992.

Craig A. Staples, Portland, argued the cause for petitioners. With him on the brief was Roberts, Reinisch, Mackenzie, Healey & Wilson, P.C., Portland.

Roger J. Leo, Portland, argued the cause for respondent Karolyn K. Teresi. With him on the brief was Leo & Horton, Portland.

Janice M. Pilkenton, Portland, waived appearance for respondent SAFECO Insurance Company.

M. Kathryn Olney, Portland, waived appearance for respondent Liberty Northwest Insurance Corporation.

Janet M. Schroer, Portland, argued the cause for respondent Western Employers Insurance.

With her on the brief was Schwabe, Williamson & Wyatt, Portland.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

DE MUNIZ, J.

Reversed and remanded for award of fees for services at hearing level to be paid by Western Employers Insurance; otherwise affirmed.

115 Or App 250 > Claimant worked as a seamstress for Dennis Uniform Manufacturing (employer) from 1977 through October, 1988, when she became an inspector. Over that time, employer had seven workers' compensation insurance carriers. Four are parties to this review. In 1983, claimant filed a claim for pain in the left hand and wrist, which Western Employers Insurance (Western), employer's insurer at the time, accepted. In March, 1984, claimant was also diagnosed as having epicondylar tendinitis of the left elbow; in August, 1984, that condition was also diagnosed in the right elbow. Claimant received treatment, but she did not lose time from work or file a new claim. Wausau Underwriters (Wausau) was then employer's insurer. SAFECO Insurance Company was employer's insurer from September, 1984, until August, 1985.

Claimant continued to have difficulties and filed a claim in September, 1986, for carpal tunnel syndrome affecting her left hand and wrist, which Liberty Northwest Insurance Corporation (Liberty), then on the risk, accepted on behalf of employer. Claimant had surgery on her left wrist in September, 1986, and the claim was closed in December, 1986, with an award for temporary disability only. Between August, 1986, and February, 1988, claimant experienced occasional flare-ups of the elbow condition.

In March, 1988, claimant filed a claim for both hands and wrists. At that time, United Pacific Insurance Company (United Pacific) was employer's insurer. Claimant's condition was diagnosed as chronic bilateral epicondylitis. She received treatment and has had minimal pain since. SAFECO, Liberty and United Pacific denied responsibility; Western denied compensability and responsibility. Wausau, the only insurer that has not participated in this proceeding, has not accepted or denied the claim.

The Board adopted the findings of the referee and held that claimant's condition is compensable as an occupational disease. It recognized that Wausau, employer's insurer when claimant first sought treatment for her condition, would ordinarily have been responsible for the claim but, because Wausau had never received a claim or been joined as a <115 Or App 250/251> party, United Pacific, as the insurer on the risk at the time of the last potentially causal exposure, is responsible. United Pacific contends that it should not be held responsible, because it made every effort to obtain the participation of Wausau.

In *Priest v. City of Hermiston*, 106 Or App 732, 809 P2d 1370, *rev den* 312 Or 527 (1991), we held that a worker satisfies his obligations under the Workers' Compensation Law by filing a claim with the

employer and establishing that the work was the cause of the condition. The worker need not file claims with every potentially responsible insurer. Under the rationale of *Runft v. SAIF*, 303 Or 493, 739 P2d 12 (1987), we concluded that, when a claimant files a claim with the employer, a notified insurer that knows of a potential dispute over responsibility has the obligation to join other potentially responsible insurers and that, if it fails to do that, it may not assert, under the last injurious exposure rule, that it is not responsible and that the nonjoined insurer is.¹

We are not persuaded by United Pacific's attempts to distinguish *Runft* and *Priest* and conclude that they require the result reached by the Board. When United Pacific denied the claim, it was aware that claimant's condition was arguably related to an earlier period of employment and that Wausau was the potentially responsible insurer. In fact, it notified Wausau of the claim and requested the issuance of an order designating a paying agent pursuant to ORS 656.307. The Department did not issue an order, because Western had denied the compensability of the claim. At the request of all parties, the hearing was postponed, so that all potentially responsible insurers, including Wausau, could be joined. Claimant had not filed a claim specifically with Wausau, opposed joining Wausau and sought to have the hearing scheduled as soon as possible, taking the position that United Pacific was responsible. United Pacific did not move to join Wausau, because it believed that it could not under the Hearings Division's rule, which expressly provided for joinder only of *subsequent* insurers.

115 Or App 252> We reject United Pacific's contention that claimant should be penalized for her failure to support United Pacific's efforts to join Wausau. As we held in *Priest v. City of Hermiston, supra*, that was United Pacific's duty, if it wished to avoid responsibility by asserting that Wausau was responsible. The Board correctly held that United Pacific, having failed to join Wausau, cannot avoid responsibility by asserting that Wausau is responsible.²

United Pacific contends that the Board erred in awarding claimant attorney fees payable by it under ORS 656.386(1), which provides, in part:

"In all cases involving accidental injuries where a claimant finally prevails in an appeal to the Court of Appeals or 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."

Only Western contested compensability. Claimant sought a hearing and received a favorable determination on the question of compensability. She prevailed finally on that issue, because Western did not appeal to the Board. Claimant is entitled to insurer-paid attorney fees under ORS 656.386(1) for services performed at the hearing level from the insurer that created the need for her to establish the compensability of the claim. That insurer is Western.

As to fees for services performed at the Board level, United Pacific argues that, because it did not contest compensability, the Board was not authorized to award attorney fees payable by it.

Compensability was an issue before the referee. Even though the parties did not raise it on Board review, the Board was authorized to make a *de novo* review of the claim, ORS 656.295(6), and *could* have decided compensability. If compensability had been raised by the Board, it could have ruled against claimant on that issue. United Pacific's appeal to the Board placed claimant's award at risk. Claimant's <115 Or App 252/253> attorney was justified in actively participating at the Board proceeding to protect claimant's interests. *SAIF v. Bates*, 94 Or App 666, 670, 767 P2d 87 (1989). The Board correctly awarded attorney fees payable by United Pacific, pursuant to ORS 656.382(2). See *International Paper Co. v. Riggs*, 114 Or App 203, 833 P2d 378 (1992).

Reversed and remanded for award of fees for services at hearing level to be paid by Western Employers Insurance; otherwise affirmed.

¹ We note that ORS 656.307 was amended in 1990 to place responsibility for joining all potentially responsible insurers on claimants. Or Laws 1990 (Spec Sess), ch 2, 49.

² United Pacific contends that, if Wausau is not responsible, Western is. We will not consider that argument, which is raised for the first time on review.

Cite as 115 Or App 330 (1992)

September 30, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Froylan L. Zurita, Claimant.

FROYLAN L. ZURITA, Petitioner,

v.

CANBY NURSERY and SAIF CORPORATION, Respondents.
(90-07147; CA A70516)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 10, 1992.

Edward J. Harri, Salem, argued the cause for petitioner. With him on the brief were Michael B. Dye and Brad G. Garber, Salem.

Thomas E. Ewing, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

ROSSMAN, J.

Affirmed.

115 Or App 332> The issue before us in this workers' compensation case is whether hearsay statements regarding the cause of an injury contained in medical reports constitute *prima facie* evidence of causation under ORS 656.310(2).

On December 12, 1989, claimant sought treatment from Dr. Miller for back pain. He did not see Miller again, but in March, 1990, he saw Dr. Poul. The doctors' reports contained claimant's account that he had injured his back loading trees at work. Claimant did not personally attend the referee's hearing. He appeared through counsel. SAIF withdrew all of the exhibits that it had previously submitted, which included the medical reports. Claimant's attorney then offered the medical reports. SAIF objected to the documents as inadmissible hearsay, because claimant was not present for cross-examination. The referee excluded the reports and upheld the denial.

ORS 656.310(2) provides, in part:

"The contents of medical, surgical and hospital reports presented by claimants for compensation shall constitute *prima facie* evidence as to the matter contained therein; so, also, shall such reports presented by the insurer or self-insured employer, provided that the doctor rendering medical and surgical reports consents to submit to cross-examination."

The Board ruled that the excluded reports should have been admitted. However, it held that the statements in the reports regarding causation do not constitute *prima facie* evidence that the injury claimant suffered occurred on the job. It reasoned:

"[H]earsay statements of matter not reasonably pertinent to diagnosis and treatment have little indicia of reliability; therefore, we do not accord them status as *prima facie* evidence and give them little weight. In this case, claimant's statements to the doctor that he hurt his back lifting and twisting are reasonably pertinent to the doctor's diagnoses and treatments. Accordingly, those statements constitute *prima facie* evidence that claimant so hurt his back.

"[C]laimant's statements in the medical reports that the lifting and twisting happened at work are not reasonably <115 Or App 332/333> pertinent to diagnosis or treatment. They are not *prima facie* evidence of the fact asserted; we accord them little weight."

Claimant argues that, under ORS 656.310(2), the complete contents of the documents constitute *prima facie* evidence of "matters contained therein," including matters regarding causation. He contends that, under *Williams v. SAIF*, 99 Or App 367, 781 P2d 1269 (1989), he was entitled to prosecute his case through counsel and was not required personally to appear at the hearing. Therefore, he argues, SAIF was required to present evidence to rebut the *prima facie* case established by the reports; and, because SAIF did not do so, the only evidence on record establishes the compensability of his injury.

Employer cites legislative history in support of the Board's interpretation that the "matter" that constitutes *prima facie* evidence under ORS 656.310(2) is statements related to diagnosis or treatment, not to causation. The statute was first enacted in 1965. Or Laws 1965, ch 285, 40. The sponsor, Representative Skelton, testified about its purpose:

"Mr. Chairman, this is the amendment which I believe is necessary for a claimant to be able to make his case out, a *prima facie* case, without having to bring in doctors, the custodian of hospital records, to testify. Under this amendment the report submitted by the claimant's doctor would become primary evidence much as in the records rule which is now under the exception to the hearsay rule; and this particular kind of language is found in almost all compensation acts. It merely will result in the referee, or the hearing officer, having before him reports which he himself takes at face value. It merely enables the claimant to make out his case without the expense and delay * * * [garbled].

* * * * *

"I have set the two standards for the simple reason that, now these are taken almost word for word out of the Wisconsin Act. Let me give you the footnote on the Wisconsin Act. It says '[t]he purpose of this provision is to equalize, to a degree, the opportunity for parties to present pertinent testimony. The cost of appearance of medical witnesses is at times prohibitive to employees. Under this provision the burden of producing the physician for cross-examination desired is imposed upon the employer or insurance company.'" (Emphasis supplied.)

115 Or App 334 > We agree that the legislative history does not demonstrate that the legislature intended that all "matter" in a medical report constitutes *prima facie* evidence. Rather, the intention was to give it that weight on *medical* issues. Under ORS 656.310(2), medical reports establish *prima facie* evidence of medical matters.

Claimant contends that giving that limiting interpretation to "matter" in ORS 656.310(2) "accomplishes everything sought to be prevented by *Williams v. SAIF*, [*supra*] * * *." We do not agree. Under *Williams*, a claimant's case cannot be dismissed if the claimant chooses to present the case through counsel. *Williams* does not stand for the proposition that, if a claimant does rely on the record, the burden of proof will necessarily be met. As we noted in *Miller v. Granite Construction Co.*, 28 Or App 473, 476, 559 P2d 944 (1977):

"[The doctor's] conclusions are valid as to the matter of causation only to the extent that the underlying basis of those opinions, the reports of claimant as to the circumstances of the accident and the extent of the resulting injury, are accurate and truthful."

The facts surrounding the occurrence of an on-the-job injury may be uniquely within a claimant's knowledge. Nonetheless, a claimant is entitled to present the case as he or she chooses. A claimant may testify personally or present other witnesses or he/she may rely on statements contained in medical reports. However, in the latter instance, a claimant runs the risk that the reports may not be sufficient to carry the burden of proof on work-connectedness.

The Board is not bound by the rules of evidence, ORS 656.283(7), and it may receive hearsay evidence and evaluate its weight in the light of the circumstances of the case. Although claimant presented sufficient evidence to reach the factfinder and there was no evidence to the contrary, nonetheless the Board could conclude that claimant's evidence was not persuasive and that he was not injured on the job.

Affirmed.

Cite as 115 Or App 335 (1992)

September 30, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Travis W. Thorpe, Claimant.

TRAVIS W. THORPE, Petitioner,
v.
SEIGE LOGGING and SAIF CORPORATION, Respondents.
(WCB 89-25141; CA A70723)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 12, 1992.

Donald M. Hooton, Eugene, argued the cause for petitioner. With him on the brief were Edward J. Harri and Malagon, Moore, Johnson & Jensen, Eugene.

Steven Cotton, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

ROSSMAN, J.

Affirmed.

115 Or App 337> Claimant seeks review of an order of the Workers' Compensation Board denying payment for certain medical services. We affirm.

The Board adopted the referee's findings:

"Claimant sustained a compensable injury to his head, upper torso, neck, and mid-back in 1978. Several years later, in 1982, SAIF formally denied the compensability of claimant's DMSO treatment. Claimant requested a hearing. In May, 1983, by way of an Opinion and Order, [the referee] set aside SAIF's denial and ordered it to continue to pay for claimant's Dimethylsulfoxide ('DMSO') treatment 'in the future.'

"In August, 1989, the Director [of the Department of Insurance and Finance (DIF)] filed WCD Admin Order 2-1989, with the Secretary of State's office. *It became effective on September 1, 1989.* One of the amendments contained in that order was former OAR [436]^[1]-10-090(24) (*new OAR [436]-10-090(26)*), which stated:

"Dimethylsulfoxide (DMSO) is not reimbursable except for treatment of compensable interstitial [sic] cystitis."

"On December 7, 1989, a SAIF claims examiner wrote a letter to Dr. Jacob, M.D., stating:

"Enclosed is a copy of the Oregon Administrative Rules regarding DMSO, OAR 436-10-090(24).

"As this is the ruling of the Workers' Compensation Division, we are unable to reimburse you for the DMSO or the injections of such.'

"Thereafter, claimant requested a hearing to appeal a 'denial of [ORS 656].245 benefits * * *.'" (Emphasis supplied.)

The referee set aside SAIF's denial of payment for medical services rendered after September 1, 1989, the effective date of OAR 436-10-090(24). The Board reversed, concluding that claimant was no

¹ The Board supplemented the referee's findings by noting that the correct chapter is OAR 436, rather than the OAR 438 reference in the referee's findings.

longer entitled to those services, because the new administrative rule permitted a redetermination of compensability of the medical treatment. The Board said:

115 Or App 338 > "The claim at issue before the earlier Referee was for DMSO treatments rendered on or prior to the 1983 hearing. Treatments rendered after the 1983 hearing represent separate causes of action and are not barred by claim preclusion."

Then the Board held that the denial of compensability was not barred by issue preclusion.²

The Board also concluded:

"[Former] OAR 436-10-003 provided that the provisions of OAR 436-10-090 *et seq.*, applied to all services rendered after the effective date of the rules. Inasmuch as claimant's claim was for DMSO treatment rendered after the September 1, 1989 effective date, OAR 436-10-090(24) is applicable to his claim." (Emphasis supplied.)

Accordingly, it reversed the referee's award of penalties and attorney fees to claimant.

Claimant acknowledges that he does not suffer from interstitial cystitis. He argues, however, that the treatment for the condition from which he does suffer was previously and finally determined to be payable in the 1983 hearing. He contends that because there was no change in his condition, the promulgation of OAR 436-10-090(24) cannot bar his eligibility for the medical services, because his right to receive them was based on the law in effect at the time of his injury in 1978.

Although claimant argues that his eligibility for payment for current DMSO treatments cannot be affected by an administrative rule change, his claim for continuing DMSO treatments has been open since 1983. The Board's order denying payment applies only to treatments rendered after September 1, 1989. It does not affect treatments provided before the effective date of OAR 436-10-090(24). Accordingly, <115 Or App 338/339> we need only decide whether the new rule applies to treatments after September 1, 1989, regardless of the date of claimant's injury.

We agree with the Board's disposition of claimant's arguments relating to claim and issue preclusion. In 1983, the referee decided only the compensability of DMSO treatments given before the 1983 hearing. The expenses here are for treatments administered after September 1, 1989. If the new rule applies to claimant's continuing medical treatments, he had the burden in 1989 of proving that the treatments were reasonable and necessary *and* were for interstitial cystitis. That last issue was not relevant to the determination of the claims in 1983. SAIF's denial is not barred either by claim or by issue preclusion. *See Drews v. EBI Companies*, 310 Or 134, 140, 795 P2d 531 (1990).

The parties agree that, under ORS 656.245(4),³ the Director of DIF is authorized to "exclude from compensability any medical treatment the director finds to be unscientific, unproven, outmoded or experimental." ORS 656.202(2) provides:

"Except as otherwise provided by law, payment of benefits for injuries or deaths under ORS 656.001 to 656.794 *shall be continued as authorized*, and in the amounts provided for, by *the law in force at the time the injury giving rise to the right to compensation occurred.*" (Emphasis supplied.)

² The Board said:

"At the time of the earlier Referee's decision, it was claimant's burden to prove that DMSO treatment was reasonable and necessary as a result of his compensable injury under the general provisions of ORS 656.245. At the time of the instant hearing, it was claimant's burden to prove DMSO treatment was reasonable and necessary and for interstitial cystitis under the specific provision of OAR 436-10-090(24). Therefore, the issue in the instant case was not before the earlier Referee. We therefore conclude that SAIF's denial is not barred on the basis of issue preclusion."

³ Subsection (4) was added to ORS 656.245 by Oregon Laws 1987, chapter 884, section 24. ORS 656.245(4) has not been amended since then, although other portions of ORS 656.245 were amended by Or Laws 1991, ch 2, 10.

656.018(1), when Broughton & Harrell purchased Jantec's stock, dissolved Jantec and acquired its assets and continued operations with the same employees as before, it retained responsibility for all of Jantec's actual and potential liabilities under ORS 60.644(4) (*since amended by Or Laws 1991, ch 883, 11*).

ORS 656.018(1)(a) provides:

"The liability of every employer who satisfies the duty required by ORS 656.017 (1) is exclusive and in place of all other liability arising out of compensable injuries to the subject workers, the workers' beneficiaries and anyone otherwise entitled to recover damages from the employer on account of such injuries or claims resulting therefrom, specifically including claims for contribution or indemnity asserted by third persons from whom damages are sought on account of such injuries, except as specifically provided otherwise in this chapter."

ORS 60.644(4) (*since amended by Or Laws 1991, ch 883, 11*)³ provides:

"A claim may be enforced under this section:

"(1) Against the dissolved corporation to the extent of its undistributed assets; or

"(2) If the assets have been distributed in liquidation against the shareholder of the dissolved corporation to the extent of the shareholder's pro rata share of the claim or the corporate assets distributed to the shareholder in liquidation, whichever is less. A shareholder's total liability for all claims under this section may not exceed the total value of assets distributed to the shareholder, as of the date or dates of distribution, less any liability of the corporation paid on <115 Or App 353/354> behalf of the corporation by that shareholder after the date of distribution."

ORS 60.644(4) makes a shareholder liable for claims against the dissolved corporation to the extent of assets that it received in liquidation. ORS 656.018(1) exempts an employer from liability for "matters concerning a claim," because an employee's exclusive remedy is under the Workers' Compensation Act. *See Gordineer v. Bellotti*, 100 Or App 102, 105-106, 785 P2d 362, *rev den* 310 Or 121 (1990). Status of an employer does not change because the employer is also a shareholder of a dissolved corporation. The statute expresses a legislative intent that an employer's liability be exclusive for work related injuries under the Workers' Compensation law. The general rule is that, when two statutes refer to the same subject matter and their applications would conflict, the specific statute prevails over the general one. *State v. Pearson*, 250 Or 54, 58, 440 P2d 229 (1968). As the sole shareholder of Jantec, Broughton & Harrell may be liable for claims against Jantec under ORS 60.644(4). However, because ORS 656.018 specifically governs the liability of employers for work-related injuries to employees, it controls over the liability imposed generally by ORS 60.644. The trial court did not err in granting summary judgment to Broughton & Harrell.⁴

Next, we address the motions of Brown and Jantec, who argue that their liability, if any, is

³ The substance of ORS 60.644(4) is now codified at ORS 60.645. *See Or Laws 1991, ch 883, 16.*

⁴ In *Perkins v. Cehlar*, 107 Or App 158, 811 P2d 690, *appeal dismissed* 312 Or 554 (1991), we held that a trustee landlord was not immune under ORS 656.018(3) because he was also a co-employee of plaintiff. We reasoned that the defendant's status as a trustee was as a legal entity distinct from his status as a co-employee and so he could be held personally liable as trustee for negligence in connection with the maintenance of the business premises. Here, Broughton & Harrell's status as an employer and as a shareholder of Jantec involve functions of the same legal entity, a corporation.

limited to that imposed by *Restatement (Second) Torts*, 388 (1965),⁵ for damages <115 Or App 354/355> caused by a failure to warn of a latent danger. They assert that this case is not governed by the common law negligence standard in *Fazzolari v. Portland School Dist. No. 1J*, 303 Or 1, 734 P2d 1326 (1987), because it involves a specialized standard of care, *i.e.*, that owed by a supplier of a dangerous product. They conclude that they cannot be liable to plaintiff under section 388, because the danger that resulted in plaintiff's injury was obvious.

In *Bellikka v. Green*, 306 Or 630, 638-639, 762 P2d 997 (1988), the plaintiff argued that the decisions in *Fazzolari v. Portland School Dist. No. 1J*, *supra*; *Kimble v. Stillwell*, 303 Or 23, 734 P2d 1344 (1987); and *Donaca v. Curry Co.*, 303 Or 30, 734 P2d 1339 (1987), required the court to abandon the common law concept of landlord liability under the *Restatement*. The court said:

"The question in the present case is not whether Fazzolari requires that this court abandon the principles set forth in the *Restatement (Second) of Torts* 356. That case does not make principles of common-law negligence apply where they otherwise would not. The question is whether the principles of modern negligence law are in conflict with the traditional rules of landowner liability set forth in the *Restatement* and, if so, which rules are more properly applied to the present situation?" 306 Or at 639.

115 Or App 356> Here, a similar issue is presented as to whether Brown's and Jantec's liability regarding a failure to warn is circumscribed by section 388 of the *Restatement*. Under that section, a supplier has no duty to warn if it has reason to believe that those for whose use the chattel is supplied will realize its dangerous condition. Plaintiff's allegations seek to impose liability for failure to warn and failure to add a safety device. In *Fuhrer v. Gearhart By the Sea, Inc.*, 306 Or 434, 438-39, 760 P2d 874 (1988), the court

⁵ *Restatement (Second) Torts*, 388 (1965) provides:

"One who supplies directly or through a third person a chattel for another to use is subject to liability to those whom the supplier should expect to use the chattel with the consent of the other or to be endangered by its probable use, for physical harm caused by the use of the chattel in the manner for which and by a person for whose use it is supplied, if the supplier

"(a) knows or has reason to know that the chattel is or is likely to be dangerous for the use for which it is supplied, and

"(b) has no reason to believe that those for whose use the chattel is supplied will realize its dangerous condition, and

"(c) fails to exercise reasonable care to inform them of its dangerous condition or of the facts which make it likely to be dangerous."

Comment k explains:

"*When warning of defects unnecessary.* One who supplies a chattel to others to use for any purpose is under a duty to exercise reasonable care to inform them of its dangerous character in so far as it is known to him, or of facts which to his knowledge make it likely to be dangerous, if, but only if, he has no reason to expect that those for whose use the chattel is supplied will discover its condition and realize the danger involved. It is not necessary for the supplier to inform those for whose use the chattel is supplied of a condition which a mere casual looking over will disclose, unless the circumstances under which the chattel is supplied are such as to make it likely that even so casual an inspection will not be made. However, the condition, although readily observable, may be one which only persons of special experience would realize to be dangerous. In such case, if the supplier, having such special experience, knows that the condition involves danger and has no reason to believe that those who use it will have such special experience as will enable them to perceive the danger, he is required to inform them of the risk of which he himself knows and which he has no reason to suppose that they will realize." (Emphasis in original.)

said that failure to warn or protect should be analyzed in terms of foreseeability and unreasonable conduct.⁶

"A defendant may be liable if the defendant can reasonably foresee that there is an unreasonable risk of harm, a reasonable person in the defendant's position would warn of the risk, the defendant has a reasonable chance to warn of the risk, the defendant does not warn of the risk, and the plaintiff is injured as a result of the failure to warn.

"There are four factors to be considered in determining whether action or a failure to act is reasonable: the likelihood of harm, the severity of the possible harm, the 'cost' of action that would prevent harm, and the defendant's position, including the defendant's relationship with the plaintiff.

"If there is a relationship between the parties, an obligation may be imposed by statute, contract or court-made law. If no special obligation is imposed by law or contract, the factfinder should determine whether action by the parties is required by the relationship and, if so, what action is required. Even if there is no relationship between the parties, *if the risk is great, either in likelihood or magnitude, and the cost is minimal, the reasonableness of the action should be determined by the factfinder.*" 306 Or at 438. (Emphasis supplied; footnote omitted.)

Failure to provide safety measures is subject to the same standard.⁷ 306 Or at 442 n 3.

We reject Brown's and Jantec's argument that their liability is governed entirely by section 388. That argument necessarily focuses on the concept of "duty," a focus rejected by *Fazzolari* and *Fuhrer*. The real issue is whether it was reasonably foreseeable that plaintiff would be injured by defendants' conduct and whether their conduct was unreasonable.

Plaintiff alleges that Brown and Jantec were negligent in removing a safety guard, failing to replace the guard and transferring the grinder to Broughton & Harrell without warning of its dangerous

⁶ The court said:

"The law traditionally has been that a defendant is liable for a failure to warn or protect only if the defendant had a 'duty' to warn or protect. This court discussed the concept of duty in negligence cases in *Fazzolari, Kimbler [v. Stillwell]*, 303 Or 23, 734 P2d 1344 (1987) and *Donaca [v. Curry Co.]*, 303 Or 30, 734 P2d 1339 (1987)]. In those cases, we held that the concept of duty was not always a useful tool with which to analyze common-law negligence. There may be specific duties established by statute, status or relationship, but the absence of such duties does not insulate a defendant from liability. In the absence of a duty arising from a source of that kind, a defendant may be liable for conduct which is unreasonable in the circumstances if that conduct results in harm to a plaintiff and the risk of harm to the plaintiff or the class of persons to whom the plaintiff belongs was foreseeable.

* * * * *

"Failure to warn or protect should be analyzed in terms of foreseeability and unreasonable conduct. If a specific affirmative duty is imposed by statute, status or relationship, an analysis based on that specific duty is also appropriate. * * * Absent an affirmative duty, the existence of a 'duty' in the given circumstances is a conclusion to be reached, not a means of analysis." 306 Or at 438.

⁷ In *Fuhrer*, the court said:

"This opinion concentrates on the failure to warn, as did the briefs of the parties. The failure to provide safety measures is measured by the same standard as the standard used for failure to warn. One factor in determining the reasonableness of any failure to warn or act is the opportunity and cost of warning or taking action. Normally, providing safety measures is more costly, and the cost may make a failure to act reasonable when a failure to warn would not be reasonable; otherwise, the analysis of the two situations should be no different. Because plaintiff has not alleged facts sufficient to constitute a claim against either defendant on a failure to warn theory, the complaint also fails on a failure to provide safety measures theory." 306 Or at 442 n 3.

condition. She alleges that they knew or had reason to know that, without the guard, the grinder was dangerous and that it was foreseeable that an employee would be injured while using it.

Brown and other employees testified that there was no guard on the grinder when it was purchased or afterwards. Brown filed an affidavit saying that, before plaintiff's injury, he was not aware of any injuries arising out of the use of the grinder and that he had not seen a guard identified in an operator's manual or on the grinder. Plaintiff presented evidence that Brown had extensive experience in the pizza business, had frequently visited Abby's and had observed how the staff performed their duties, including the grinding of <115 Or App 357/358> cheese. There is also evidence that Jantec's management was aware of the danger of the machine without a guard, because several employees had requested that one be added. Jantec's former district manager testified that the grinder had holes that looked like something could have been bolted through. It would have cost approximately \$150 to make a guard. Before the transfer, a representative of Broughton & Harrell had inspected the grinder and indicated that Jantec should obtain a guard.

Brown, as a corporate officer is not protected from personal liability if he authorized, directed or participated in tortious conduct. *Beri, Inc. v. Salishan Properties, Inc.*, 282 Or 569, 580, 580 P2d 173 (1978); *Wampler v. Palmerton*, 250 Or 65, 77, 439 P2d 601 (1968). We conclude that there is a genuine issue of material fact as to whether Brown was negligent in failing to direct the placement of a safety guard on the grinder. A trier of fact could infer that he had reason to know that the grinder should have a guard and that his conduct unreasonably created a foreseeable risk to plaintiff.⁸

Although it is not clear from the record whether plaintiff is seeking to hold Jantec liable apart from any liability of Broughton & Harrell as a shareholder of the dissolved corporation, we address Jantec's separate liability. In the light of the testimony about Brown's knowledge of the dangerous condition of the grinder, there is also an issue of fact as to whether Jantec was negligent on the basis of *respondet superior* when it transferred the grinder without installing a safety guard. Because, arguably, the risk of harm is great and the cost is minimal, the reasonableness of defendants' conduct should be determined by the factfinder. *Fuhrer v. Gearhart By the Sea, Inc.*, *supra*, 306 Or at 439.

Brown and Jantec contend that they are also immune from liability under ORS 656.018(1). The short answer to that argument is that neither of them was plaintiff's employer at the time of the injury. Jantec points to the fact that plaintiff was an employee of Jantec when the grinder <115 Or App 358/359> was transferred to Broughton & Harrell, which is the gravamen of the claim. Although the purported negligence may have occurred when plaintiff was Jantec's employee, ORS 656.018(1) only provides immunity from liability for those who are "employers" *at the time of the injury*. See ORS 656.005(13). Plaintiff's claims against Jantec and Brown constitute third party claims against potentially responsible tortfeasors under ORS 656.154.

Jantec and Brown also argue that plaintiff's injuries were caused by her own contributory negligence.⁹ Whether plaintiff acted reasonably must be answered by a trier of fact after hearing the evidence, not decided as a matter of law. *Dahl v. BMW*, 304 Or 558, 566, 748 P2d 77 (1987).

The trial court erred when it granted summary judgment to Jantec and Brown.

Reversed and remanded as to Jantec, Inc., and Edgar C. Brown; otherwise affirmed.

⁸ There is no evidence that Brown removed a safety guard from the grinder. He did not transfer the grinder to Broughton & Harrell. The transfer was from Jantec after Brown sold his stock.

⁹ Warning signs were permanently affixed to each side of the grinder, warning the user: "DANGER NEVER PUT HAND INTO FEED HOPPER." At the request of a supervisor, plaintiff had prepared a sign that was posted on a wall near the grinder: "Caution * * * when this machine is in use, please remember to use the correct procedure." A few months before the accident, plaintiff had a similar accident that had bruised her right thumb while she was feeding cheese into the grinder.

Cite as 115 Or App 371 (1992)

September 30, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Herman M. Carlson, Claimant.

HERMAN M. CARLSON, Petitioner,
v.
VALLEY MECHANICAL, Respondent.
(90-09177; CA A69753)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 20, 1992.

Edward H. Harri, Salem, argued the cause for petitioner. With him on the brief were Stanley F. Fields and the Law Office of Michael B. Dye, Salem.

Jerald P. Keene, Portland, waived oral argument for respondent. With him on the brief was Roberts, Reinisch, Mackenzie, Healey & Wilson, P.C., Portland.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

DE MUNIZ, J.

Affirmed.

115 Or App 373 > Claimant seeks review of a Workers' Compensation Board order that denied his aggravation claim. We affirm.

Claimant was injured in 1984. His aggravation rights expired on December 10, 1989. On November 15, 1989, his employer received chart notes from his chiropractor. Employer treated the notes as a claim for aggravation, which it denied.

On April 30, 1990, claimant requested a hearing on the denial. The hearing was convened on July 3, 1990. The referee, applying 1990 amendments to the Workers' Compensation Law, affirmed employer's denial. She concluded, first, that the doctor's chart notes did not suffice as a claim for aggravation and, second, that, even if they did, claimant had not established that his condition had worsened. The Board adopted the referee's order with supplementation and affirmed. Claimant seeks review, arguing that the Board erred in applying the new law to him, either because the legislation was not intended to apply retroactively or because such an application would be unconstitutional.

The first question is whether the chiropractor's chart notes suffice as a claim for aggravation. Before it was amended in 1990, ORS 656.273(3) provided:

"A physician's report indicating a need for further medical services or additional compensation is a claim for aggravation."

As amended in 1990, the statute now provides:

"A physician's report establishing the worsened condition by written medical evidence supported by objective findings is a claim for aggravation."

Claimant argues that the Board erred in applying the amendment to ORS 656.273(3), which did not become effective until 1990, to determine whether the chart notes submitted in 1989 were a claim for aggravation.

Claimant's argument is persuasive; however, we need not decide that issue because, even if we accept that the chart notes were a claim, the referee decided on the merits that, under the 1990 law, claimant had failed to prove an aggravation. The Board adopted the referee's order. If the <115 Or App 373/374> 1990 amendments apply to a determination on the merits of a claim for aggravation filed in December, 1989, it is irrelevant in this case whether it was correct in its alternative determination regarding the technical requirements for filing an aggravation claim.

When it enacted the 1990 amendments, the legislature indicated its intent regarding claims that were to be subject to the new law. Oregon Laws 1990, chapter 2, section 54 provides, as relevant:

"(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 Hearing 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." (Emphasis supplied.)

As we explained in *SAIF v. Herron*, 114 Or App 64, 836 P2d 131 (1992), subsection 54(1) means that, except for certain amendments not relevant here, the 1990 amendments apply to all claims existing on July 1, 1990, regardless of the date of injury. Although we found the initial exception clause in section 54(1) ambiguous, there is nothing ambiguous about the part of the section that is pertinent to this case. Assuming that the chart notes constituted a claim for aggravation, the legislature explicitly directed that that claim, because it was existing on July 1, is subject to the new amendments.

Our conclusion that the legislature intended that claims such as this one be determined under the 1990 amendments is strengthened by the litigation savings clause, subsection 54(2). Under that subsection, matters concerning a claim that were in litigation and for which a hearing was requested before May 1, 1990, and convened before July 1, 1990, are to be determined according to the law in effect before July 1, 1990. The necessary corollary to that language <115 Or App 374/375> is that, if there is a matter concerning a claim that was in litigation when the 1990 amendments become effective, and if the hearing was *not* convened before July 1, the matter is *not* to be determined according to the law in effect before July 1, 1990. That must mean that the 1990 amendments apply to the determination. Because the hearing on claimant's claim for aggravation was not held until July 3, it must be determined under the 1990 amendments. Or Laws 1990, ch 2, 54(1).

Claimant next asserts that the evidence proved a worsening of his condition. There is substantial evidence to support the Board's finding that he did not have a compensable aggravation.

Finally, claimant argues that retroactive application of the 1990 amendments is unconstitutional. So far as we can discern, those arguments relate to the constitutionality of applying the amendments to a determination of whether the chart notes constituted a claim. We need not address those arguments for the reason stated above. We do not understand claimant's constitutional arguments to relate to application of the amendments to the merits of his aggravation claim.

Affirmed.

Cite as 115 Or App 390 (1992)

September 30, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Dale E. Holden, Claimant.

HEWLETT-PACKARD COMPANY, Petitioner,

v.

DALE E. HOLDEN, Respondent.
(90-11918; CA A72743)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 24, 1992.

Karen O'Kasey, Portland, argued the cause for petitioner. With her on the brief was Schwabe, Williamson & Wyatt, Portland.

Darris K. Rowell, Salem, argued the cause for respondent. With him on the brief was Olson, Rowell & Walsh, Salem.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

PER CURIAM

Affirmed.

115 Or App 391> In this workers' compensation case, employer seeks review of an order of the Board affirming the referee's decision to allow claimant's claim for a knee injury. Employer argues that the Board erred in finding that the cause of the injury was work-related and in determining that the claim was supported by objective medical findings. ORS 656.005(7)(a), (19).

Substantial evidence supports the Board's finding that the knee injury was work-related. Additionally, the Board found that claimant's doctor noted claimant's subjective complaints of sharp pain, a catching sensation, particularly with twisting motions and, also, "notable patellar crepitus" in response to motion and internal rotation. The doctor's report constitutes objective findings. *Georgia-Pacific v. Ferrer*, 114 Or App 471, 835 P2d 949 (1992).

Employer's remaining argument does not require discussion.

Affirmed.

Cite as 115 Or App 460 (1992)

October 14, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Lloyd G. Crowley, Claimant.

LLOYD G. CROWLEY, Petitioner,

v.

SAIF CORPORATION and CHILDREN'S SERVICES DIVISION, Respondents.
(WCB 89-01325; CA A68253)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 27, 1992.

W. Todd Westmoreland and Westmoreland & Shebley, P.C., Tillamook, filed the brief for petitioner.

John T. Bagg, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem. Before Richardson, Presiding Judge, and Deits and Durham, Judges.

RICHARDSON, P.J.

Affirmed.

115 Or App 462> Claimant seeks review of a Workers' Compensation Board order holding that his mental disorder is not compensable. He contends that the compensability of the mental disorder should have been determined under the law regarding an industrial injury and not that regarding an occupational disease. He also argues that, if the disorder is an occupational disease, it did not result from reasonable corrective action of his employer.

Although the Board reversed the referee's determination that the illness is compensable, it accepted his findings, which neither party disputes:

"[Claimant] was employed by this employer (Children's Services Division) at Camp Tillamook in July, 1986. He was a Group Life Coordinator II which involved counseling juveniles confined to the correction camp in Tillamook. On August 19, 1988 claimant was advised of a sexual harassment accusation by a female co-worker. Claimant 'went to pieces'.

* * * * *

"An investigation of the charges was made by claimant's supervisor, who didn't believe the charges. He concluded that claimant had made some remarks which were susceptible of misinterpretation, and [during an employee conference] cautioned claimant as to his conversation with this co-worker in the future. There was NO disciplinary

action taken. The investigation which was made by claimant's supervisor was actually preliminary to any disciplinary action which might be taken.

" * * * * *

"In addition, claimant was taking medication for his hypertension condition (which he had done for several years) which would predispose him to a depressive episode from psychic trauma. That, combined with the sexual harassment accusation precipitated an emotional disorder [specifically 'depression and anxiety'] of such magnitude that claimant wasn't able to continue working."

Claimant argues that the Board erred by analyzing his mental disorder as an occupational disease under *former* <115 Or App 462/463> ORS 656.802.¹ He is wrong. *SAIF v. Hukari*, 113 Or App 475, 833 P2d 1307 (1992).

Former ORS 656.802 provided, in part:

"(2) Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter:

" * * * * *

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

The Board concluded that claimant's mental disorder resulted from the employee conference that he had with his supervisor. It held that the conference was corrective action and, because it was reasonable, the mental disorder was not compensable under *former* ORS 656.802(2)(b).

Claimant first argues that the mental disorder resulted from the false accusation by the female employee, not from the conference. The Board gave a reasoned conclusion on the basis of findings that are supported by substantial evidence. It rejected the fine distinction that claimant wishes to draw that his awareness of the allegation, not the supervisor's corrective action, produced the reaction.

Claimant next argues that the employee conference was not disciplinary action under *former* ORS 656.802(2)(b). The Board found, and there was substantial evidence to support the findings, that the employee conference was a required prelude to any direct disciplinary action. It also concluded that, in any event, the meeting was a corrective action by employer.

Claimant's final contention is that, even if the employee conference was corrective action, it was not reasonable. The Board concluded otherwise, and that is supported by substantial evidence and substantial reasoning.

Affirmed.

¹ *Former* ORS 656.802, as amended, became effective January 1, 1988. It was again amended on July 1, 1990. Or Laws 1990, ch 2, 43. Claimant agrees that the 1988 version of the statute is applicable.

Cite as 115 Or App 506 (1992)October 14, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Vincent B. Sweeney, Claimant.

SAIF CORPORATION and **SWEENEY SIDING**, Petitioners,

v.

VINCENT B. SWEENEY, Respondent.

(90-09754; CA A68897)

Judicial Review from Workers' Compensation Board.

Argued and submitted November 13, 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.

Dennis O'Malley, Portland, argued the cause and filed the brief for respondent.

Before Richardson, Presiding Judge, and Joseph, Chief Judge, and Deits, Judge.

DEITS, J.

Remanded for reconsideration of extent of permanent partial disability; otherwise affirmed.

115 Or App 508 > Employer seeks review of the Workers' Compensation Board's order that held that it did not have the authority to re-evaluate and reduce payments on a permanent partial disability (PPD) award that had been suspended during claimant's participation in vocational rehabilitation and which assessed a penalty and attorney fees against it for unreasonable claim processing.

Claimant suffered a back injury on the job in 1988. Employer accepted the claim, and a determination order was issued on July 28, 1989, awarding temporary disability from the time of the injury until June 12, 1989, and 36 percent unscheduled PPD. Claimant applied for a lump sum payment, which was approved. Neither claimant nor employer requested a hearing on the determination order. On July 30, 1989, claimant entered an authorized vocational rehabilitation program. Under the applicable statutes and rules, payment of claimant's PPD award was suspended during his participation in vocational training. On March 23, 1990, claimant was examined at employer's request. He completed the vocational rehabilitation program on April 13, 1990, and began work for a new employer on April 16, 1990. On April 30, 1990, employer issued a notice of closure, by which it re-evaluated and reduced claimant's PPD award from 36 percent to 17 percent. Subsequently, employer paid claimant a lump sum award of 17 percent.

Claimant requested a hearing. The referee held that employer did not have the authority to reduce claimant's award in its notice of closure and ordered it to pay the 36 percent award in the 1989 determination order. The referee reasoned that the 1989 determination order had become final 180 days after it was issued and that employer should have begun paying on it as soon as claimant finished the training program. The referee concluded, however, that claimant's disability was 25 percent and authorized an offset of the difference between the 36 percent and 25 percent against any future award of permanent disability. The referee also assessed a penalty against employer and ordered it to pay attorney fees.

115 Or App 509 > On review, the Board held that, because the 1989 determination order had become final by operation of law, employer did not have the authority to re-evaluate and reduce claimant's award. The Board reversed the referee's reduction of claimant's PPD award, as well as the attorney fees related to the increase of the employer closure award from 17 percent PPD to 25 percent, awarded attorney fees for Board review and otherwise affirmed.

Employer assigns error to the Board's holding that it did not have the authority to re-evaluate and reduce claimant's original PPD award after he had finished the vocational rehabilitation program. Employer argues that, after a worker completes a vocational rehabilitation program, an earlier determination order may be determined anew and the previous award, even if it has become final, may be adjusted.

The pertinent statute is ORS 656.268(5):¹

*"If, after the determination made or notice of closure issued pursuant to subsection (3) or (4) of this section, the worker becomes enrolled and actively engaged in training * * *, any permanent disability payments due under the determination shall be suspended, and the worker shall receive temporary disability compensation while the worker is enrolled and actively engaged in the training. When the worker ceases to be enrolled and actively engaged in the training, the Department of Insurance and Finance shall redetermine the claim pursuant to subsection (4) of this section unless the worker's condition is not medically stationary. If the worker has returned to work, the insurer or self-insured employer may reevaluate and close the claim without the issuance of a determination order by the Department of Insurance and Finance."* (Emphasis supplied.)

Under that statute, *payments* on a permanent disability award are suspended while the worker is involved in training. However, the statute does not provide that the determination order itself is affected when the worker enters a training program. The administrative rules that implement the statute also provide only for *suspension* of permanent disability payments while the worker is involved in a training program. OAR 436-60-040 provides:

115 Or App 510 > "(2) When training commences in accordance with OAR 436-120 after the issuance of a determination order, * * * the insurer shall suspend any award payments due under the order * * * and pay temporary disability benefits.

"(3) The insurer shall stop temporary disability compensation payments and resume any suspended award payments upon the worker's completion or the ending of the training, unless the worker is not then medically stationary. If no award payment remains due, temporary disability compensation payments shall continue pending a subsequent determination order by Evaluation. However, if the worker has returned to work, the insurer may reevaluate and close the claim without the issuance of a determination order by Evaluation." (Emphasis supplied.)

Employer argues that, because the statute permits it to re-evaluate a previous permanent disability award after the completion of vocational rehabilitation and close the claim without the issuance of a new determination order if the worker has returned to work, it can refuse to resume payments on the earlier award until it has redetermined the amount due. We disagree. As the Board said:

"[W]e do not agree with SAIF that, because it had the right to reevaluate and close the claim at the end of claimant's formal training program, the July 28, 1989 Determination Order, in effect, became null and void and it is only required to pay claimant the permanent disability awarded under its April 30, 1990 Notice of Closure. *The option of reevaluating and closing the claim by notice of closure is an alternative to resubmitting the claim for determination under ORS 656.268(4), which provides for the determination of any further compensation owed, including permanent disability. See ORS 656.268(5). It is not an alternative to resuming the payment of the suspended award. Thus, given the fact that the original determination had become final by operation of law, the Referee correctly found that SAIF was required to resume the suspended payments owed thereunder.*" (Emphasis supplied.)

We conclude that, when an employer chooses the alternative of re-evaluation under ORS 656.268(5), rather than submitting the claim for redetermination, it must follow normal procedures for carrier closure. ORS 656.268(3)(b). If a claimant requests reconsideration of the closure award, the <115 Or App 510/511> employer is obligated to resume payment of the initial award until the claimant's extent of disability is redetermined.

¹ ORS 656.268 has since been amended, Or Laws 1990, ch 2, 16; Or Laws 1991, ch 502, 1, but the amendments do not apply in this case.

Although we agree with the Board's conclusion that employer must comply with the original determination order unless and until claimant's disability is re-evaluated, we do not agree that, in its re-evaluation, employer may not reduce the extent of disability. We find nothing in the statute or rules that provides that the re-evaluation permitted after vocational rehabilitation can only result in a claimant's receiving benefits for an equal or greater disability. In providing for re-evaluation in ORS 656.268(5), the legislature apparently recognized that the extent of a claimant's disability may change as a result of participation in a vocational rehabilitation program. In *Leedy v. Knox*, 34 Or App 911, 920, 581 P2d 530 (1978),² it was recognized that, although an initial determination order must be based on the claimant's condition before training, the extent of disability can be reexamined after training:

"If a claimant is able to reduce the extent of his or her disability through participation in a rehabilitation program, provision has been made for re-evaluation and reduction of the permanent award."

Claimant relies on the language of ORS 656.268(4) for his argument that an employer may not reduce the extent of a claimant's disability in the re-evaluation. That subsection provides:

"Within 10 working days after [DIF] receives the medical and vocational reports relating to a disabling injury, the claim shall be examined and further compensation, including permanent disability award, if any, determined under the director's supervision. If necessary [DIF] * * * may postpone the determination * * *. When the worker requests a redetermination of claim closure * * *, the division shall grant a personal interview with the worker and make such a redetermination. [DIF] shall reconsider determinations * * * whenever one of the parties makes request therefor and presents medical information regarding the claim that was not available at the time the original determination was made." (Emphasis supplied.)

115 Or App 512> Claimant contends that, by its use of the word "further," the legislature meant that a claimant's disability can only be increased. However, subsection (4) is not applicable here. The claim was closed under subsections (3) and (5).

Employer was entitled to re-evaluate the extent of disability after claimant completed the program. However, employer was obligated to make payments under the 1989 determination order when claimant completed the rehabilitation program until the re-evaluation process was complete. When employer issued a notice of closure under ORS 656.268(5), it was required to follow the usual procedures for carrier closure. If a claimant does not seek review of an employer's re-evaluation, or a new determination order is issued, only then may an employer pay the adjusted compensation.³

Employer also argues that the Board erred in finding that its refusal to pay the initial award was unreasonable and in assessing a penalty and attorney fees against it for unreasonable claims processing. Employer was required to resume payment of the initial award when claimant completed the vocational rehabilitation program. The Board did not err in concluding that employer's treatment of the initial award was invalid and that its refusal to pay that amount was unreasonable.

Remanded for reconsideration of extent of permanent partial disability; otherwise affirmed.

² ORS 656.268(3) and ORS 656.268(4) have been amended and renumbered ORS 656.268(4) and ORS 656.283(5), respectively. Or Laws 1990, ch 2, 16. However, the portion of the statute addressed in *Leedy* is essentially unchanged.

³ In a case such as this, where a claimant is entitled to a lump sum payment under the first determination order, the reevaluation may have little immediate effect. However, the statute and the rules do not differentiate between lump sum payments and monthly payments.

Cite as 115 Or App 521 (1992)

October 14, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
 In the Matter of the Compensation of Grace L. Stephen, Claimant.

ROBERT L. STEPHEN, Personal Representative of the Estate of Grace L. Stephen, Petitioner,

v.

OREGON SHIPYARDS and SAIF CORPORATION, Respondents.

(85-14678; CA A63036)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 14, 1992.

Eileen G. Simpson, Portland, argued the cause for petitioner. With her on the brief were Donald M. Hooton and Peter O. Hansen, Portland.

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.

DEITS, J.

Affirmed.

115 Or App 523> Claimant¹ seeks review of an order of the Workers' Compensation Board holding that she is not entitled to permanent total disability (PTD) because, even though her compensable condition prevented her from returning to the workplace, she did not show that, but for the condition, she was willing to seek work. We affirm.

The facts are not in dispute. Between 1942 and 1945, claimant worked as a welder in employer's shipyards, where she was exposed to asbestos. Her work with employer ended in 1945, after which she did not work or seek work, but stayed home to raise her children. She developed laryngeal cancer, later determined to be compensable, and had two surgeries because of that condition in 1962 and 1971. After the 1962 surgery, claimant's physical condition prevented her from reentering the work force. She later developed a heart condition, unrelated to her compensable condition, which also prevented her from returning to work.

The issue is whether claimant is entitled to PTD.² In *SAIF v. Stephen*, 308 Or 41, 774 P2d 1103 (1989), the Supreme Court remanded this case to the Board. It held that a claimant who voluntarily leaves the work force and later becomes totally disabled due to a compensable condition is entitled to PTD only if the claimant can establish that, "but for the compensable injury, she is or would be willing to seek regular gainful employment *and* has or would have made reasonable efforts to do so." 308 Or at 43. (Emphasis in original.) The court remanded for findings on the question of whether claimant was willing to return to work. On remand, the Board denied PTD:

"We are persuaded that, by the time of hearing, claimant was prevented from returning to work, assuming she had been so inclined, by either her noncompensable cardiovascular disease or her compensable cancer condition. Yet, we are unable to find that she is or was willing to seek regular gainful employment. At most, the record suggests that, upon reflection, claimant had entertained the possibility of a <115 Or App 523/524> return to work as a welder at some indefinite time prior to developing her compensable cancer. Such speculation does not lead us to the conclusion that, but for the compensable injury, claimant would have returned to work."

Claimant argues that the Board's denial of PTD was in error, because any effort on her part to return to the work force would have been futile due to her disability and that she was not required to

¹ Claimant is deceased; her personal representative has been substituted.

² Claimant's condition was determined compensable in 1984. In 1985, a determination order awarded her 100 percent unscheduled permanent partial disability.

engage in futile acts. Claimant is correct that a worker whose compensable condition renders her unable to seek gainful employment need not establish that she "has made reasonable efforts to obtain such employment" under ORS 656.206(3).³ However, a claimant must still prove that, but for the compensable condition, she would be willing to seek regular gainful employment. *SAIF v. Stephen*, *supra*, 308 Or at 48; *SAIF v. Beswick*, 104 Or App 494, 802 P2d 82 (1990).

The Board found that claimant did not show her willingness to seek work had she not suffered from laryngeal cancer. There is substantial evidence in the record to support that finding. The Board did not err in concluding that claimant did not meet her burden of proving her willingness to return to the work force under ORS 656.206(3).

Affirmed.

³ ORS 656.206(3) provides:

"The worker has the burden of proving permanent total disability status and must establish that the worker is willing to seek regular gainful employment and that the worker has made reasonable efforts to obtain such employment."

Cite as 115 Or App 525 (1992)

October 14, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Angela J. Peterson, Claimant.

ANGELA J. PETERSON, Petitioner,

v.

JEV INC. and SAIF CORPORATION, Respondents.
(90-04311; CA A69926)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 24, 1992.

Karen M. Werner, Eugene, argued the cause for petitioner. With her on the brief were Allan H. Coons and Coons, Cole & Cary, P.C., Eugene.

Steve 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 Richardson, Presiding Judge, and Deits and Durham, Judges.

DEITS, J.

Affirmed.

115 Or App 527> Claimant seeks review of an order of the Workers' Compensation Board upholding employer's refusal to pay interim compensation. We affirm.

Claimant sustained a compensable injury to her back in May, 1988. An August 25, 1989, determination order declared claimant medically stationary as of June 27, 1989, and awarded her time loss and permanent partial disability. On August 9, 1989, claimant fell and suffered an increase in symptoms of her condition. By letters of August 15 and 16, claimant's chiropractor advised employer of the August 9 incident and increased symptoms. Claimant's condition improved after the fall and did not worsen after the August 25 determination order was issued.

Employer denied claimant's request for additional compensation for the August 9 incident. Claimant did not challenge the August 25 determination order. However, she did seek review of employer's denial of her claim and employer's failure to pay interim compensation between August 9, the date of her fall, and January, 1990, when employer denied her claim. She also sought penalties and attorney fees for employer's allegedly unreasonable failure to process her claim. The Board upheld employer's denial.

Claimant argues that the Board erred in failing to order employer to pay interim compensation and in refusing to award penalties and attorney fees. She contends that, even if she did not prove an aggravation claim, employer had a procedural duty to pay interim compensation between the time of claimant's 1989 claim and its 1990 denial of the claim.

As authority for an award of interim compensation, claimant relies on ORS 656.273(6),¹ which governs only the payment of interim compensation for an aggravation claim. <115 Or App 527/528 > Under ORS 656.273(1),² an aggravation occurs when,

"[a]fter 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."

The last arrangement of compensation was on August 25, 1989. Claimant's fall and the flare up of symptoms on which she bases her claim for additional compensation occurred on August 9. Because the alleged worsening occurred *before* the last arrangement of compensation, claimant's claim could not be for an aggravation. Accordingly, no interim compensation was due under ORS 656.273(6).

As the Board recognized, claimant's argument really is that the August 25, 1989, determination order was premature. However, that issue could only have been raised in an appeal of the August 25 order, which claimant did not do. As the referee explained:

"But for the fact the Determination Order was not timely appealed from, claimant would be asking to have the Determination Order set aside as prematurely issued. However, claimant cannot raise premature claim closure because of her failure to timely appeal the Determination Order. Claimant's attempt to litigate premature closure under the guise of an aggravation claim must fail."

Employer's refusal to pay additional compensation for the August 9 incident was proper.

Affirmed.

¹ ORS 656.273(6) then provided:

"A claim submitted in accordance with this section shall be processed by the insurer or self-insured employer in accordance with the provisions of ORS 656.262, except that the first instalment of compensation due under ORS 656.262(4) shall be paid no later than the 14th day after the subject employer has notice or knowledge of medically verified inability to work resulting from the worsened condition."

The statute has since been amended. Or Laws 1990, ch 2, 18.

² The statute has since been amended. Or Laws 1990, ch 2, 18.

Cite as 115 Or App 564 (1992)

October 14, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Dennis L. Barnes, Claimant.

DENNIS L. BARNES, Petitioner,

v.

SAIF CORPORATION and LYNN BARNES, Respondents.

(90-10562; CA A70461)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 24, 1992.

Karen M. Werner, Eugene, argued the cause for petitioner. With her on the brief were James C. Egan and Emmons, Kropp, Kryger, Alexander & Egan, P.C., Albany.

Julie Bolt, Special Assistant Attorney General, Salem, argued the cause for respondents. With her on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Deits and Durham, Judges.

DURHAM, J.

Affirmed.

115 Or App 566 > Claimant seeks review of a Workers' Compensation Board order holding that his claim is barred by the Statute of Limitations. The issue is whether SAIF gave claimant sufficient notice that it had denied part of his claim. We affirm.

On September 22, 1989, employer sent claimant a document labeled "Notice of Claim Acceptance" that stated, in part:

"Your claim has been accepted for the following condition(s):

"Fracture right glenoid neck and right mid clavicle.

"Lacerations to the right ear, right forehead and right cheek.

"Cerebral contusion right temporal parietal region.

"Contusions and abrasions right arm, shoulder and knee.

"PARTIAL DENIAL: SAIF Corporation denies responsibility for your pre-existing bifrontal episodic headaches and irritable bowel syndrome as being neither caused nor worsened by your injury of August 7, 1989."

The second page gave the date, claimant's name and claim number and bore the caption "NOTICE OF ACCEPTANCE AND PARTIAL DENIAL." It informed claimant that he had 60 days to request a hearing to contest the denial and that he would lose all rights after 180 days.

Claimant assigns error to the Board's determination that the letter was an effective notice of a partial denial. The parties stipulated that claimant received the letter in September or October, 1989. He requested review more than 180 days later. He concedes that, if the letter was a valid partial denial, his claim is time-barred.

Claimant argues that notice of acceptance requirements differ from those for a notice of denial and that a notice that does not clearly apprise the claimant of a claim denial is invalid. He argues that the denial notice was "buried" in the body of the acceptance and that the format and conflicting notices rendered the notice of denial invalid. We disagree.

ORS 656.262(6) provides, in part:

"Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer * * * within 90 days after the employer has notice or knowledge of the claim. <115 Or App 566/567> * * * The notice of acceptance shall:

"(a) Specify what conditions are compensable.

"(b) Advise the claimant whether the claim is considered disabling or nondisabling."

OAR 436-60-140(3) provides the same requirements. OAR 436-60-140(4) provides that a notice of denial

"shall comply with the rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law and shall:

"(a) Specify the factual and legal reasons for the denial; and

"(b) Inform the worker of the Expedited Claim Service and of the worker's right to a hearing under ORS 656.283."

OAR 438-05-060 requires a partial denial to "set forth with particularity the injury, or condition, benefit or service for which responsibility is denied and the factual and legal reasons therefor." The document meets the requirements for a notice of acceptance and of partial denial.

Claimant cites two cases, *Johnson v. Spectra Physics*, 303 Or 49, 733 P2d 1367 (1987), and *Price v. SAIF*, 296 Or 311, 675 P2d 479 (1984), to support his argument that a partial denial must appear in a separate document. Those cases hold that employers and insurers may issue partial denials. In *Johnson v. Spectra Physics, supra*, 303 Or at 58, the court held that, in a partial denial, "the insurer should inform the claimant of the reasons for the partial denial, allowing the claimant to appeal the denial promptly." SAIF's notice did that. Neither the use of a single document nor the language accepting specified conditions rendered the partial denial of other conditions ambiguous, misleading or otherwise defective.

Affirmed.

Cite as 115 Or App 568 (1992)

October 14, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of William R. Nelson, Claimant.

WILLIAM R. NELSON, Petitioner,

v.

SPARC ENTERPRISES and SAIF CORPORATION, Respondents.
(90-04657; CA A70460)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 28, 1992.

Robert L. Ackerman, Springfield, argued the cause for petitioner. With him on the brief was Ackerman, DeWenter & Huntsberger, P.C., Springfield.

Thomas E. Ewing, Assistant Attorney General, Salem, argued the cause for respondent. With him on the brief were Dave Frohmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Deits and Durham, Judges.

DURHAM, J.

Affirmed.

115 Or App 570 > Claimant seeks review of a Worker's Compensation Board order denying compensability of his claim. The issue is whether substantial evidence supports the Board's conclusion that claimant failed to prove that his hernia condition is causally related to his employment. We affirm.

Claimant worked as a lawn-maintenance supervisor. On October 19, 1989, he filed a worker's compensation claim for a shoulder injury that he had sustained that day. Four days later, Dr. Purtzer examined claimant's shoulder. Claimant also asked him about a bulge in his groin. Purtzer referred him to Dr. McCall, whom claimant saw on December 18, 1989. McCall diagnosed left and right inguinal hernias. The same day, claimant filed a worker's compensation claim for the hernias. He alleged that he had suffered the injury while lifting a lawn mower into a truck on June 1, 1989, at 9:45 a.m. Employer denied the claim.

At the hearing, claimant explained that he did not know the exact date of his injury but estimated that it had occurred in late June or early July, 1989. He testified that, on the day he was injured, he reported the incident and left work early. His time card, and that of Park, who claimant said witnessed the accident, showed that they left work at noon on June 5, 1989. Park substantially corroborated claimant's testimony, except that he testified that claimant returned to work after he was injured. Claimant used three hours of sick leave on July 21, 1989. Park did not work that day. During the rest of June and July, claimant and Park worked eight hours every day, with occasional overtime. Claimant's supervisor's assistant testified that claimant and Park reported an injury to her in mid-July, 1989, at about 1:30 p.m. Claimant testified that he experienced severe pain from the hernias and that he had difficulty performing even simple tasks. His work records, however, disclose no time loss or problems with fulfilling his duties. The referee found that claimant was not a credible witness and upheld SAIF's denial. The Board affirmed.

Claimant assigns error to the Board's determination that he was not credible. Employer's time records and the <115 Or App 570/571> statements of other witnesses directly contradict his testimony. There was evidence that Park, the only witness who agreed with claimant's version of the events surrounding the injury, was a disgruntled former employee who had pledged to extract revenge from his supervisor and employer's customers. Substantial evidence supports the Board's decision.

Claimant also argues that, under *Taylor v. Multnomah County School Dist. No. 1*, 109 Or App 499, 820 P2d 825 (1991), his lack of credibility about the date of injury does not necessitate the conclusion that his injury is not compensable. In *Taylor*, we held that, even if a claimant is not credible, we must determine whether substantial evidence supports a conclusion that the claim is not compensable.

Substantial evidence supports the Board's decision. Claimant's testimony, which the Board was

entitled to reject, concerned not only the date of the alleged injury but whether an injury happened at work. That distinguishes this case from *Taylor*, where the claimant's inconsistent testimony concerned his history of back treatment, not whether his injury was caused by the employment.

Affirmed.

Cite as 115 Or App 651 (1992)

October 21, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Theron Stiehl, Claimant.

Theron Stiehl, Petitioner,

v.

TIMBER PRODUCTS and SAIF CORPORATION, Respondents.
(WCB 89-10062; CA A69536)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 18, 1992.

Donald M. Hooton, Eugene, argued the cause for petitioner. On the brief were Dale C. Johnson and Malagon, Moore & Johnson, Eugene.

David L. Runner, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Dave Frohnmayer, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Warren, Presiding Judge, and Riggs and Edmonds, Judges.

RIGGS, J.

Affirmed.

115 Or App 653 > Petitioner seeks review of an order of the Workers' Compensation Board that treatments he received from a naturopathic physician were outside the scope of the physician's license and therefore not compensable. Petitioner argues that the Board did not have the authority to determine that issue and that SAIF should have been required to pay for the treatments, leaving it to recover those payments later in the event that the Board of Naturopathic Examiners determined that the physician acted beyond the scope of his license. We affirm.

Petitioner sustained a compensable injury to his hands. He received treatment with limited success from a hand surgeon and then sought treatment from Dr. Kadish, a naturopathic physician. Kadish's treatment primarily consisted of trigger point injections that relieved some of claimant's symptoms. SAIF agreed that the injection treatment would have been "reasonable and necessary," and compensable, but for the fact that the person who administered the treatment was not authorized to do so. SAIF argues that it is authorized to pay for "medical services" only and that such services are those provided by a "medical service provider," who is "a person duly licensed to practice one or more of the healing arts" acting within the scope of the license. OAR 436-10-005(25), (26); see also OAR 436-10-050. SAIF then argues that Kadish acted beyond the scope of his naturopathic license, as limited by ORS 685.030(4):

"Nothing in this chapter shall be construed to:

"(4) Authorize the administration of any substance by the penetration of the skin or mucous membrane of the human body for a therapeutic purpose [by a naturopathic physician]."

Claimant argues that the Board is not authorized to determine the scope of a physician's license, because that is not a matter concerning a claim. ORS 656.704(3). The Board disagreed and, on the basis of the referee's findings, which the Board adopted, concluded that the trigger point injections were administered for a therapeutic purpose and were, therefore, beyond the scope of Kadish's medical license.

115 Or App 654 > ORS 656.704(3) provides, in part, that

"matters concerning a claim * * * are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue."

In this case, whether Kadish acted within the scope of his license in administering trigger point injections is a "matter in which [claimant's] right to receive compensation * * * is directly in issue." ORS 656.704(3). The Board's conclusion that Kadish acted beyond the scope of his license is supported by substantial evidence and affects *only* this claimant's right to receive compensation for the treatment at issue.

Claimant's other assignments of error do not merit discussion.

Affirmed.

Cite as 115 Or App 668 (1992)

October 21, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Ronald M. Lyday, Claimant.

RONALD M. LYDAY, Petitioner,

v.

LIBERTY NORTHWEST INSURANCE CORPORATION, and EMBARCADERO RESORT, Respondents.
(WCB No. 88-04125; CA A67809)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 8, 1991.

Mark L. Malco, Newport, argued the cause and filed the brief for petitioner.

William H. Walters, Portland, argued the cause for respondents. With him on the brief were Brian B. Doherty and Miller, Nash, Wiener, Hager & Carlsen, Portland.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

DE MUNIZ, J.

Affirmed.

115 Or App 670 > Claimant seeks review of a Workers' Compensation Board order, arguing that the Board lacked jurisdiction to consider an appeal of the referee's order. We affirm.

The hearing record was closed on March 29, 1989. The referee's order, which upheld the claim, was entered and mailed to the parties on April 20, 1989. On May 12, 1989, employer moved to disqualify the referee and to have the matter resubmitted to a different referee. On May 18, 1989, the referee issued an "order of abatement." The presiding referee denied employer's motion to disqualify the referee on July 20, 1989. On September 29, 1989, the referee republished the April 20 order. Employer appealed to the Board on October 26, 1989.

Claimant moved to dismiss employer's appeal on the ground that it was untimely. The Board concluded that the appeal was timely, because it was filed within 30 days of the date of the republished order.

ORS 656.289(1) provides:

"Upon the conclusion of any hearing, or prior thereto with the concurrence of the parties, the referee shall promptly and not later than 30 days after the hearing determine the matter and make an order in accordance with the referee's determination."

That statute requires that the referee issue an order not later than 30 days after the hearing. The referee complied with ORS 656.289(1) when she issued April 20 order.

OAR 438-07-025(1) provides:

"The referee may reopen the record and reconsider his or her decision before a notice of appeal is filed or, if none is filed, before the appeal period expires. Reconsideration may be upon the referee's own motion or upon a motion by a party showing error, omission, misconstruction of an applicable statute or the discovery of new material evidence."

The rule authorized the referee to reopen the record "before time for requesting review expires." Claimant contends that ORS 656.289(1) restricts the referee's authority to make any order or determination after 30 days from the date of the <115 Or App 670/671> hearing and that OAR 438-07-025(1) conflicts with the statute, because it authorizes the referee to act after that time.

We need not decide whether there is a conflict between the rule and the statute or whether the referee would have been authorized to reopen the record. Here, the referee did not purport to reopen the record; she abated her decision, thereby nullifying it. *Black's Law Dictionary* 4 (5th Ed 1979).

The abatement effected a withdrawal of the decision. In *SAIF v. Fisher*, 100 Or App 288, 785 P2d 1082 (1990), we held that the Board has authority to withdraw an order before the 30-day period for seeking review has expired:

"In the absence of a statutory provision limiting its authority to do so, an agency has plenary authority to decide matters committed to it by the legislature. *That authority includes the authority to withdraw an order* and to reconsider the decision embodied in the order." 100 Or App at 291. (Emphasis supplied.)

There is no reason why the same rule should not apply to an order of the referee, unless ORS 656.289(1) somehow limits the referee's authority to act. We conclude that it does not. Although ORS 656.289(1) requires the referee to issue an order within 30 days of the hearing, it does not purport to restrict the referee's authority to act after that time or to withdraw that order before the time for appealing it to the Board has expired. Absent some clear indication that ORS 656.289(1) is intended to do more than set a 30-day period for the issuance of an order, we conclude that it is no more than a deadline for the issuance of an order. *See, e.g.,* ORS 197.855. Failure to comply with the statute may subject the referee to mandamus, for example, but it does not deprive the referee of the power to act. We hold that the referee has authority to withdraw or abate a decision before the time for appeal to the Board has expired. *See Farmers Insurance Group v. SAIF*, 301 Or 612, 724 P2d 799 (1986).

The referee abated her decision within the 30-day period. Employer's request for review was filed within 30 days after the issuance of the republished order. Accordingly, the Board had jurisdiction to review the order as republished.

Affirmed.

Cite as 115 Or App 692 (1992)

October 21, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
 In the Matter of the Compensation of Jimmy R. Harris, Claimant.

JIMMY R. HARRIS, Petitioner,

v.

IRELAND TRUCKING and SAIF CORPORATION, Respondents.
 (90-07799; CA A70364)

Judicial Review from Workers' Compensation Board.

Argued and submitted on February 28, 1992.

Donald M. Hooton, Eugene, argued the cause for petitioner. With him on the brief was Malagon, Moore & Johnson, Eugene.

Steve 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 Richardson, Presiding Judge, and Deits and Durham, Judges.

DURHAM, J.

Affirmed.

115 Or App 694> Claimant seeks review of an order of the workers' Compensation Board that SAIF is entitled to an offset of \$5,517.87 against his future benefits. *Former* ORS 656.268(10)¹ (*since amended and renumbered by Or Laws 1990, ch 2, 16*). We affirm.

Claimant was injured in July, 1980. SAIF accepted the claim and began paying him \$320 weekly in temporary total disability benefits. In 1986, he requested benefits based on a higher wage rate. On March 14, 1986, the Board ordered SAIF to pay \$351.20 weekly and to pay a lump sum based on that rate to cover underpayments from November 3, 1983, to the date of the order. SAIF paid claimant \$8,020.98, which included \$5,517.87 for the period *before* November 3, 1983. On April 27, 1989, a determination order issued, awarding claimant permanent total disability and awarding SAIF an offset of other previously paid benefits against future benefits.² SAIF discovered that it had overpaid claimant for the period before November 3, 1983. It began offsetting payments to recoup that amount. Claimant requested a hearing. The referee awarded SAIF an offset, and the Board affirmed.

On review, claimant disputes for the first time whether he was overpaid. However, he stipulated at the hearing that he was. He also asserts that the Board had no jurisdiction to authorize the offset, because SAIF never appealed the determination order and claim preclusion bars it from asserting an offset.

115 Or App 695> In *Drews v. EBI Companies*, 310 Or 134, 795 P2d 531 (1990), the worker was injured and a determination order had issued that awarded him disability benefits based on an incorrect wage rate.

¹ *Former* ORS 656.268(10) provided:

"Any determination or notice of closure made under subsection (3), (4) or (5) of this section may include necessary adjustments in compensation paid or payable prior to the determination or notice of closure, including disallowance of permanent disability payments prematurely made, crediting temporary disability payments against permanent disability awards and payment of temporary disability payments which were payable but not paid."

² The 1989 determination order provides, in part:

"The Department orders the insurer to pay you permanent total disability benefits beginning Feb. 21, 1989. You should have received additional payments for temporary total disability from Jun [sic] 20, 1983 through Feb 20, 1989. Any temporary disability benefits paid after that date may be deducted from permanent total disability benefits. The insurer may stop paying any permanent partial disability benefits now. Any payment for permanent partial disability made after Feb 20, 1989 may be recovered by the insurer from your permanent total disability benefits * * *."

He did not know that the rate was incorrect. Later, he claimed an aggravation of the injury, which the employer denied. A second determination order reopened the claim. 310 Or at 145 n 10. Before the hearing, the worker discovered that the rate was too low. He added the issue of the amount of past benefits to the request for hearing. The Board concluded that any litigation about the rate was barred by claim preclusion. The Supreme Court reversed. It held that, because the worker's aggravation claim had not been closed and the time to appeal that claim had not elapsed, he could challenge the wage rate that would apply to that claim. 310 Or at 150. The court also held that claim preclusion barred the worker from asserting that the amounts he received *before* the first determination order were incorrect:

"[T]he original claim was closed and final in 1981. Correction of TTD amounts paid before that closure is barred by claim preclusion even though the subject was not litigated. The administrative proceeding related to the original 1981 claim for compensation is final in all respects which are not inconsistent with the statutory scheme authorizing additional claims when and if the effects of an injury worsen in the future." 310 Or at 150 n 13.

However, that holding does not decide this case. In *Drews*, the court also held that claim preclusion is subject to an exception called "splitting":

"A final determination is not conclusive when, by provision of a statute or valid rule of the body making the final determination, that determination does not bar another action or proceeding on the same transactional claim." 310 Or at 141.

SAIF relies on OAR 436-60-170 as authority for the offset, even though it failed to litigate the issue before the April 27, 1989, determination order. OAR 436-60-170 provides, in part:

"(1) Insurers may recover overpayment of benefits paid to a worker only as specified in ORS 656.268(10), unless authority is granted by a referee or the Workers' Compensation Board."

115 Or App 696 > Claimant does not argue that OAR 436-60-170 is invalid. See *Forney v. Western States Plywood*, 66 Or App 155, 158, 672 P2d 1376 (1983), *aff'd on other grounds* 297 Or 628, 686 P2d 1027 (1984). We conclude that OAR 436-60-170 authorizes the Board to grant the offset.

Affirmed.

Cite as 115 Or App 715 (1992)

October 21, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Hubert W. Barker, Claimant.

HUBERT W. BARKER, Petitioner,
v.
FARMERS PACKING CO. and SAIF CORPORATION, Respondents.
(87-00261; CA A71219)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 13, 1992.

Edward J. Harri, Salem, argued the cause for petitioner. With him on the brief was Malagon, Moore & Johnson, Eugene.

Julie K. Bolt, Special Assistant Attorney General, Salem, argued the cause for respondents. With her on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Deits and Durham, Judges.

DURHAM, J.

Affirmed.

115 Or App 717> Claimant was injured in 1974 and has not worked since. In a 1990 order, the Board found that claimant had not established a willingness to work, that he was able to do gainful, light work and that he had refused a job offer. It also found that he suffered a 65 percent unscheduled permanent total disability (PTD) and had a functional overlay but was not entitled to PTD benefits, because he could work. Claimant sought review. We remanded for reconsideration, because substantial evidence did not support the Board's finding that claimant had a functional overlay and we could not tell whether that finding had influenced its decision. *Barker v. Farmers Packing Co.*, 107 Or App 376, 812 P2d 22 (1991). On remand, the Board said that claimant did not have functional overlay, stated that the functional overlay finding had not affected its decision and adhered to its former order.¹

Claimant seeks review of the order on remand, asserting that the Board failed to provide a reasoned explanation for its conclusion. We disagree. Although the Board did not explain why it adhered to its earlier conclusion even without proof of functional overlay, the original order and the order on remand, when read together, provide a reasoned explanation for the denial of PTD. Claimant had to prove that he is unable regularly to perform work at a gainful and suitable occupation. ORS 656.206(1)(a); *Wilson v. Weyerhaeuser*, 30 Or App 403, 409, 567 P2d 567 (1977). The Board found that claimant turned down gainful employment and that he could work. Claimant's doctors felt that he could perform the offered work. Substantial evidence supported the Board's decision. *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206, 752 P2d 312 (1988).

Affirmed.

¹ The Board's order says:

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

Cite as 115 Or App 732 (1992)

October 21, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
 In the Matter of the Compensation of Gregg Lewis, Claimant.

PRECISION CASTPARTS CORPORATION, Petitioner,

v.

GREGG LEWIS, Respondent.

(90-05265; CA A70402)

In Banc

Judicial Review from Workers' Compensation Board.

Argued and submitted January 17, 1992; resubmitted in banc August 5, 1992.

Karen O'Kasey, Portland, argued the cause for petitioner. With her on the brief were Stephen R. Rasmussen and Schwabe, Williamson & Wyatt, Portland.

Martin L. Alvey, Portland, argued the cause for respondent. With him on the brief was William H. Skalak, Portland.

Before Richardson, Presiding Judge, and Deits and Durham, Judges.

DURHAM, J.

Affirmed.

Warren, J., dissenting.

115 Or App 734> Employer seeks review of an order of the Workers' Compensation Board that reversed the referee in part and awarded claimant compensation. We affirm.

In August, 1989, claimant injured his back at work. Employer accepted the claim as nondisabling. Claimant continued to work and began receiving medical treatment. In December, he suffered back pain and was temporarily disabled. Dr. Barnhouse authorized time loss, but claimant continued to work. He filed a claim for medical services. On February 27, 1990, employer denied the claim. On March 2, claimant again experienced back pain and was taken off work for 14 days. On March 3, he filed another claim for medical services. On March 13, employer denied that claim.

The Board set aside the denials on the ground that employer had failed to give proper notice to the director of the Department of Insurance and Finance (DIF) that claimant's injury had become disabling. It held that the denials had no effect and ordered employer to pay claimant benefits.

As an initial matter, employer asserts that the law in effect after July 1, 1990, should apply to this case because a hearing was not convened before July 1, 1990. Or Laws 1990 (Spec Sess), ch 2, 54(2) provides:

"(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."

Claimant requested a hearing on March 8, 1990, and the Board originally scheduled it for July 27. On June 1, the Board issued a "Notice of Accelerated Hearing," which set the hearing for June 25 at a Salem hotel. The parties waived the notice of procedures required by ORS 183.413 and stipulated that theirs was a contested case. The referee preserved all objections and motions, took no evidence and continued the hearing until July 27. Employer argues that

the accelerated hearing was a sham. We rejected employer's argument in <115 Or App 734/735> *Astoria Plywood Co. v. Culp*, 115 Or App 737, ___ P2d ___ (1992).¹

Employer also contends that the Board erred by considering the February 27 denial, when employer sought review only of the March 13 denial.² The Board was not confined on review to the issues that the parties raised. It had the authority to address any issue that was before the referee, even in the absence of a cross-petition for review of that issue. See *Destael v. Nicolai Co.*, 80 Or App 596, 600, 723 P2d 348 (1986). The Board did not err when it considered the February 27 denial.

Finally, employer argues that the Board erred when it set aside the denials on the ground that employer did not give immediate notice to the director of the DIF.³ Former ORS 656.262(12) (repealed by Or Laws 1990 (Spec Sess) ch 2, 15) provided in part:

"If within one year after the injury, a worker claims a nondisabling injury has become disabling, the insurer or self-insured employer shall report the claim to the director immediately after receiving notice or knowledge of such claim."

Employer sent copies of the February 27 and March 13 denials to the Workers' Compensation Division. The Division received notice of the first denial no fewer than 58 days after claimant had reported in December, 1989, that he was temporarily disabled. Employer issued the second denial 10 days after the second claim was made. The Board held that employer's delay in reporting to the Division that claimant asserted that his injury had become disabling was not "immediate" notice under former ORS 656.262(12). We give careful consideration to the Board's interpretation of the statute and agree that employer failed to give immediate notice. The Board did not err when it set aside the denials.

115 Or App 736> Affirmed.

¹ The record of the accelerated hearing in this case is nearly identical to that quoted in *Astoria Plywood Co. v. Culp*, *supra*, 115 Or App at 739 n 1, except that employer appeared at the hearing, waived a notice of rights under ORS 183.413 and stipulated that this is a contested case under ORS chapter 656.

² The referee upheld the February 27 denial and set aside the March 13 denial.

³ Although claimant raised the issue as an aggravation claim, the Board correctly determined that it was not an aggravation, because it occurred within one year after the injury. See former ORS 656.262(12) (repealed by Or Laws 1990 (Spec Sess), ch 2, 15).

WARREN, J., dissenting.

I dissent for the reasons stated in my dissent in *Astoria Plywood Co. v. Culp*, 115 Or App 737, ___ P2d ___ (1992).

Joseph, C.J., and Buttler and Edmonds, JJ, join in this dissent.

Cite as 115 Or App 737 (1992)

October 21, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
 In the Matter of the Compensation of Gary L. Culp, Claimant.

ASTORIA PLYWOOD COMPANY, Petitioner,

v.

GARY L. CULP and LIBERTY NORTHWEST INSURANCE CORPORATION, Respondents.
 (90-12785, 90-04277; CA A71622)

In Banc

Judicial Review from Workers' Compensation Board.

Argued and submitted April 10, 1992; resubmitted in banc August 5, 1992.

Jaurene R. Judy, Portland, argued the cause for petitioner. With her on the brief was G. Joseph Gorciak, Portland.

Martin L. Alvey, Portland, argued the cause for respondent Gary L. Culp. With him on the brief was William H. Skalak & Associates, Portland.

No appearance by respondent Liberty Northwest Insurance Corporation.

DURHAM, J.

Affirmed.

Warren, J., dissenting.

115 Or App 739> Employer appeals from a Workers' Compensation Board order affirming a permanent partial disability (PPD) award to claimant. Employer contends that the Board erred in applying pre-July 1, 1990, law to this case, because a hearing was not convened before that date, as required by Or Laws 1990 (Spec Sess), ch 2, 54(2). Employer also contends that the Board's conclusion that claimant's back condition is compensable is not supported by substantial evidence. We affirm.

On May 2, 1987, claimant compensably injured his knee. Employer accepted the claim, which was closed by a January 11, 1988, determination order. On March 21, 1988, claimant compensably injured his back. Employer accepted the claim, which was closed on July 13, 1988, with an award for time loss. In April, 1989, claimant's knee symptoms worsened, and he filed an aggravation claim. That claim was resolved by a stipulation on February 1, 1990. On August 19, 1989, he walked down stairs, felt pain in his right knee, fell and again injured his back. On January 2, 1990, employer denied compensability of the back condition. On February 26, 1990, claimant requested a hearing on the denial. The Board scheduled a hearing for July 12, 1990.

On May 7, 1990, the legislature passed a statute revising the Workers' Compensation Law but excepted certain claims in litigation. Or Laws 1990 (Spec Sess), ch 2, 54(2) provides:

"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 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." (Emphasis supplied.)

The Board did not conduct a hearing in this case on July 12, 1990. Instead, it issued a notice to the parties and conducted a proceeding on June

25, 1990, before a referee. The transcript¹ indicates that the referee announced that he <115 Or App 739/740> officially convened the hearing on the merits, acknowledged the appearance of claimants' counsel, admitted an exhibit, obtained counsel's waiver of a notice of the rights of the parties in workers' compensation cases, preserved objections or motions by any party to the convening of the hearing before July 1, 1990, and recessed the hearing to a later date. Employer made no appearance. The proceeding occurred at a <115 Or App 740/741> Salem hotel and was one of many proceedings conducted in a similar manner that day.

¹ The transcript of the June 25, 1990, proceeding says:

"Hearing in the above-entitled matter was held in Salem, Oregon on the 25th day of June, 1990 at a.m., before John Baker, Referee for the Workers' Compensation Board of the State of Oregon.

TRANSCRIPT OF HEARING

"THE REFEREE: Pursuant to Notice this is the time and place set to convene the hearings on the merits in the matters of the compensation of each and every case listed in and described in those certain official records of the Workers' Compensation Board. Consisting in these hearings of three pages, now marked and admitted in this record as Exhibit 412.

"In each and every one of these cases the claimant's attorney of record, Patrick Lavis, appears at this time by Attorney Martin Elvey--Alvey, A-L-V-E-Y--

"MR. ALVEY: Alvey.

"THE REFEREE: --of claimant's attorney.

"As to the insurers and employers, legal notice has been provided and their representatives have appeared in the official pro forma manner prescribed today by the Workers' Compensation Board, or, in the alternative having received legal notice, have waived appearance in these cases.

"These hearings are being recorded by Diane Kliever of the Workers' Compensation Board.

"These hearings are of course, officialy [sic] convened.

"Mr. Alvey, do you waive reading of the notice to parties of Rights and Procedures in Workers' Compensation Cases promulgated pursuant to ORS 183.413?

"MR. ALVEY: Yes.

"THE REFEREE: Do you agree that these are contested cases under ORS Chapter 656?

"MR. ALVEY: Yes.

"THE REFEREE: All objections or motions from any party to the convening of these hearings prior to July 1, 1990, are preserved and may be raised at the continued hearing, at which time the Referee will rule.

"These hearings are now recessed and continued to a date and time to be set by the Docket Section of the Hearings Division.

"Thank you very much.

"MR. ALVEY: Thank you.

(OFF THE RECORD)"

The record does not explain the reason for the procedure, but we can intuit it. The Board's backlog prevented it from scheduling many cases within the 90-day deadline set by ORS 656.283(4).² For example, the original July 12, 1990, hearing in this case was set 136 days after the request for hearing was filed. The problem was further complicated by the May 7, 1990, amendment, which declared that a claim would be governed by the new law if a hearing was not convened prior to July 1, 1990. A party who had requested a hearing on or before April 1, 1990, would be legally entitled to a hearing before July 1, 1990, but, due to the backlog, it would not be set by that date and the new law would govern the claim. The Board convened the abbreviated proceedings so that its backlog, a problem not within the control of any party, would not deprive parties who had requested a hearing by April 1, 1990, of the right to have the pre-July 1, 1990, law govern their proceedings.

Employer contends that the referee did not "convene a hearing" within the meaning of the 1990 amendment, that the Board had no authority to schedule a hearing on June 25, 1990, and that the proceeding on that date was a sham, because "[i]ts sole purpose was to force hundreds of cases to be decided under the old law."

The 1990 amendment does not specially define the terms "convene" or "hearing." Accordingly, we discern the legislature's intention by giving them their natural, plain and obvious meaning, if there is one. *Perez v. State Farm Mutual Ins. Co.*, 289 Or 295, 299, 613 P2d 32 (1980); see *City of Portland v. Smith*, 314 Or 178, 186, 838 P2d 568 (1992). A common definition of "convene" is:

"1. to come together or assemble, usually for some public purpose; 2. to cause to assemble; convoke; 3. to summon to appear, as before a judicial officer." *Random House <115 Or App 741/742> Dictionary of the English Language* 443 (unabridged 2d ed 1987).

A common definition of "hearing" is:

"3. opportunity to be heard * * * 4. an instance or a session in which testimony and arguments are presented, esp. before an official, as a judge in a lawsuit." *Random House Dictionary of the English Language* 882 (unabridged 2d ed 1987).

Another common meaning for "hearing" is "a trial before an administrative tribunal." *Webster's Third New International Dictionary* 1044 (unabridged 1976).

The legislative history of the 1990 amendment is instructive. On May 4, 1990, Representative Mannix explained the "litigation" exception to the Interim Special Committee on Workers' Compensation:

"There's literally at least 20,000 cases in litigation right now, and without some special exemption with the operative dates here, technically any of those cases going to hearing or going through the appellate process would have to be revisited as to the language of this Act, and as the lawyers on this committee know, that would be a nightmare. So it would allow those cases where there's been a request for hearing filed before May 1 and the hearing is held by July 1 of this year, to continue through the

² ORS 656.283(4) provides:

"The board shall refer the request for hearing to a referee for determination as expeditiously as possible. The hearing shall be scheduled for a date not more than 90 days after receipt by the board of the request for hearing. The hearing shall not be postponed except in extraordinary circumstances beyond the control of the requesting party."

system under the standards in effect at the time that the cases were filed and not apply this law to them." Tape Recording, Interim Special Committee on Workers' Compensation, May 4, 1990, Tape 21, Side B at 230-244.

On May 7, 1990, Mannix again explained that provision during the House floor debate:

"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 260.

Mannix's language was imprecise. On May 4, he used the phrase "hearing is held," and on May 7 referred to the standards in effect on the date the case is "tried." However, he was describing a bill that used the phrase "hearing was convened." <115 Or App 742/743> Mannix's statements do not suggest that he understood the words "convene" and "hearing" to have a definition different from the ordinary definitions that we have discussed. These are instances in which, "although Mannix's language was inaccurate, it is possible for us to glean his meaning." *SAIF v. Herron*, 114 Or App 64, 70, 836 P2d 131 (1992). The legislature's overriding concern was to avoid the cost and frustration of applying the new law to cases that had progressed to a hearing convened before July 1, 1990. The legislature could have excepted only those hearings that had reached an advanced stage, such as the taking of testimony or argument, but did not do so.

The continuance of the June 25, 1990, proceeding, a common event in any adjudication, does not determine whether the hearing was convened. The Board's motive also does not decide the issue. The proceeding involved no testimony or argument, but it did involve several procedures common to administrative hearings. The referee summoned the parties, opened the hearing record, acknowledged the presence or absence of the parties, admitted an exhibit, obtained claimants' acknowledgement that the proceeding was a contested case under ORS ch 656 and a waiver of claimants' rights under ORS 183.413 to a notice of hearing procedures, and afforded the parties an opportunity to be heard, at least with respect to those procedures. He conducted an initial part of the hearing. Because he convened the parties and commenced the hearing before July 1, 1990, the Board did not err in applying pre-July 1, 1990, law to this case.

We reject the employer's argument that the Board had no authority to schedule the June 25, 1990, proceeding after it had initially set a hearing on July 12, 1990. The Board may conduct a hearing on 10 days' notice to the parties. ORS 656.283(5). Nothing prevents it from accelerating a requested hearing, so long as it complies with the notice requirement. Employer does not argue that it did not receive a timely notice of the hearing.

Finally, employer assigns error to the Board's determination that claimant had established the compensability of his back condition. We review for substantial evidence and errors of law. ORS 656.298(6); ORS 183.482(7), (8). Several doctors gave different opinions of the cause of claimant's <115 Or App 743/744> injury. The referee found that claimant was credible. He also accepted the opinion of Dr. Young, who believed that meniscal tears caused claimant to fall and hurt his back. In *Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206, 752 P2d 312 (1988), says:

"[I]f there are doctors on both sides of a medical issue, whichever way the Board finds the facts will probably have substantial evidentiary support."

This is such a case.

Affirmed.

WARREN, J., dissenting.

When the legislature significantly altered the workers' compensation laws in 1990, it specifically provided that matters concerning a claim for which a hearing had been requested before May 1, 1990, and for which the hearing was convened before July 1, 1990, would be decided pursuant to the pre-amendment law. Or Laws 1990 (Spec Sess), ch 2, 54(2). I agree with employer that the proceeding held on June 25, 1990, was a sham. Accordingly, I dissent.

Because the 1990 amendments apply to all cases for which a hearing had not yet "convened," the Board gave notice of and held a "rights preservation conference" on June 25, 1990, at a Salem hotel. This case was one of approximately 2,500 that were "convened" that day. The sole purpose of the conference was to enable those cases to be decided under the old law. No issues relating to this case were raised on June 25, and the referee preserved all objections and motions until the regularly scheduled hearing, which was eventually held on December 5, 1990. Employer did not attend the June conference, but objected to the rights preservation conference when the hearing was finally held on December 5.

The majority purports to rely on the natural, plain and obvious meaning of the terms "convene" and "hearing." Although I have no quarrel with that approach, and agree with the definitions offered for the terms, I must disagree with the majority's application of the definitions.

"Convene" means, according to the majority, "to come together or assemble, usually for some public purpose." 115 Or App at 741. The record indicates that a proceeding was <115 Or App 744/745> convened when the referee assembled the mass of cases on June 25.

The fact is, however, that the proceeding that was convened was not a "hearing" under any definition of that term, including the majority's. It defines "hearing" as "an opportunity to be heard" or "a session in which testimony and arguments are presented." 115 Or App at 742. Having defined the term, the majority then ignores the definition. The transcript, which is quoted in its entirety in note 1 of the majority opinion, shows that the proceeding never provided claimant or employer an opportunity to be heard, nor was any testimony or argument offered or solicited. There simply was not a hearing. The Board's attempt to preserve claimant's rights under the old law was nothing but a sham proceeding.

When the legislature adopted the amendments at the special session, it was aware of the Board's backlog of cases. Had it intended that all claimants whose cases were part of that backlog should have their claims adjudicated under the old law, it simply could have exempted all cases for which a request for hearing had been filed before May 1, 1990. It did not. For whatever reason, it specifically provided that the old law would apply *only* to cases in which requests for hearing had been made before May 1, 1990, *and* a hearing had been convened before July 1, 1990. Neither the Board nor we are at liberty to ignore the legislature's clear directive.

When the legislature exempted from the new law cases for which a hearing had been convened, it meant that the process of adjudicating a disputed claim must have begun. Claimant does not contend--nor could he--that the referee began to adjudicate any disputed issues in his case at the so-called rights preservation conference. Accordingly, I would hold that the Board and the referee erred in applying the old law to this case.

I dissent.

Joseph, C.J., and Buttler and Edmonds, JJ, join in this dissent.

Cite as 116 Or App 10 (1992)

October 28, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Virgil R. Hutson, Claimant.

VIRGIL R. HUTSON, Petitioner,

v.

PRECISION CONSTRUCTION and LIBERTY NORTHWEST INSURANCE CORPORATION, Respondents.
(WCB 90-15307; CA A72725)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 18, 1992.

Kevin Keaney, Portland, argued the cause for petitioner. With him on the brief was Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Alexander D. Libmann, Portland, argued the cause for respondents. With him on the brief was M. Kathryn Olney, Portland.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

BUTTLER, P.J.

Affirmed.

116 Or App 12> Claimant seeks review of an order of the Workers' Compensation Board determining the extent of disability from his compensable back injury.

In 1986, claimant injured his back at work, and SAIF accepted the claim, which was closed in December, 1987. In June, 1989, claimant began to experience back pain again. SAIF denied responsibility, as did Liberty, employer's current insurance carrier. After the issuance of an order under ORS 656.307, the referee determined that Liberty is responsible.

Claimant has psoriasis that predates the 1986 injury. In January, 1990, the psoriasis became symptomatic. He claimed that the flare-up was work-related, caused by his emotional response to his back injury. Treatment was effective and, by June, 1990, the condition had abated. Liberty denied compensability of the psoriasis and asked the Department of Insurance and Finance (DIF) to close the injury. The claim was closed in August, 1990, with an additional 4% award of unscheduled disability for the back injury.

At the hearing, claimant contended that his psoriasis is compensable as a part of the back injury claim and that, because liability for the psoriasis had been denied, the claim had been prematurely closed. In the alternative, he argued that the award should have included benefits for permanent unscheduled disability resulting from the psoriasis. Claimant offered a medical report by which he sought to establish that the extent of his permanent disability was affected by the psoriasis, which he alleged was caused by a psychological condition related to the stress of his employment subsequent to and as a consequence of the back injury. Employer objected to the evidence on the ground that it was irrelevant, because neither the psoriasis, liability for which had been denied, nor the alleged stress condition are properly considered parts of the claim.

The referee admitted the report. He set aside the denial of liability for the psoriasis, finding that it is a consequence of the accepted low back claim. He set aside the determination order on the ground that it was premature and **<116 Or App 12/13>** remanded the claim to Liberty for acceptance and the payment of compensation for the psoriasis. On review, the Board held that claim closure was not premature because, at the time of the determination order, the psoriasis was medically stationary. Instead of setting aside the determination order, the Board reevaluated the extent of claimant's disability, taking into consideration the back condition *and the psoriasis*.

Despite what he argued at the hearing, claimant now contends that the Board erred in rating his disability from the psoriasis, rather than remanding the claim to DIF for evaluation. He argues that only DIF may rate a disability in the first instance and that the Board had no authority to rate it.

Although, as claimant contends, initial responsibility for evaluating a claim is DIF's or the insurer's, see ORS 656.298, the Board has the authority to review extent of disability. ORS 656.295. Claimant has always contended that psoriasis was part of his back injury claim. DIF evaluated and closed the claim without considering claimant's psoriasis. Claimant contended that the evaluation had wrongly omitted consideration of that condition. The Board agreed and reevaluated the claim, properly taking the psoriasis into account and increased claimant's award from 4% to 13% unscheduled permanent disability.

Affirmed.

Cite as 116 Or App 62 (1992)

October 28, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Rocky L. Coble, Claimant.

ROCKY L. COBLE, Petitioner,

v.

T. W. KRAUS & SONS and SAIF CORPORATION, Respondents.
(90-10159; CA A71932)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 14, 1992.

David C. Force, Salem, argued the cause for petitioner. With him on the brief was Vick & Gutzler, Salem.

Steven R. Cotton, Special Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

PER CURIAM

Affirmed.

116 Or App 63> Claimant seeks review of an order of the Workers' Compensation Board holding that employer was entitled unilaterally to terminate benefits for temporary total disability when claimant was released for work.

Claimant suffered a compensable injury in 1989. On March 7, 1990, before he had become medically stationary, he was released for work. Employer unilaterally terminated his temporary total disability benefits as of that date. Claimant requested a hearing on May 10, 1990. The hearing was held on August 2, 1990.

Before it was amended by Oregon Laws 1990, chapter 2, section 16, ORS 656.268 provided that claims shall not be closed "nor temporary disability compensation terminated" if the worker's condition is not medically stationary. See *Fazzolari v. United Beer Distributors*, 91 Or App 592, 595, 757 P2d 857 (1988). ORS 656.268(3) now provides:

"Temporary total disability benefits shall continue until whichever of the following events first occurs:

"(a) The worker returns to regular or modified employment;

"(b) The attending physician gives the worker a written release to return to regular employment * * * [.]"

The amended version of ORS 656.268 is applicable to this claim. *Carlson v. Valley Mechanical*, 115 Or App 371, 838 P2d 637 (1992).

Affirmed.

Cite as 116 Or App 64 (1992)

November 4, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Theresa J. Lester, Claimant (Dec'd).

LIBERTY NORTHWEST INSURANCE CORPORATION and **OREGON ASPHALT PAVING**, Petitioners,
v.

JILL E. GOLDEN, Personal Representative of the Estate of Theresa J. Lester,
Deceased, Respondent.
(WCB TP-90061; CA A68913)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 27, 1992.

M. Kathryn Olney, Portland, argued the cause and filed the brief for petitioners.

Gene Mechanic, Portland, argued the cause for respondent. With him on the brief were Goldberg & Mechanic, Portland, and W. Eugene Hallman and Mautz, Hallman, Pendleton.

Before Richardson, Presiding Judge, and Deits and Durham, Judges.

RICHARDSON, P.J.

Remanded for reconsideration of distribution; otherwise affirmed.

Durham, J., concurring in part; dissenting in part.

116 Or App 66> Petitioners seek review of a third-party distribution order of the Workers' Compensation Board issued under ORS 656.593(3). They contend that the lien provided under ORS 656.593(1) should be paid from the third-party settlement before any of the proceeds are allocated or distributed to any beneficiaries of the worker. They also contest the Board's calculation of the amount of the lien. We remand.

Theresa Lester (decedent) was killed when she was hit by a truck while working as a flagger for petitioner Oregon Asphalt Paving (employer). She was survived by her husband and two minor children. Petitioner Liberty Northwest Insurance Corporation (Liberty) was the workers' compensation insurer for employer. It accepted a workers' compensation claim and pays benefits to decedent's husband and children: \$806.84 per month to husband and \$150 per month for each child. ORS 656.204.

Respondent, the personal representative of decedent's estate, brought a wrongful death action for the benefit of the husband and the children against the driver of the truck that hit decedent. The truck driver's carrier offered to settle the action for \$300,000. Liberty did not object to the amount of the settlement¹ and respondent petitioned the probate court for an order apportioning the settlement to the beneficiaries under ORS 30.040. With the husband's concurrence, the probate court allocated one-half of the settlement to each child and nothing to husband.

Respondent then petitioned the Board to resolve a dispute as to the distribution of the settlement proceeds, particularly the amount that Liberty

¹ Petitioners do not contend that the settlement is void because they did not approve it in writing. ORS 656.587.

could recover on its lien. Liberty requested that all of the costs of the claim, including benefits paid to the husband and the children, be paid under ORS 656.593. The Board held that the claim costs attributable to an individual beneficiary should be payable only from the amount of the settlement allocated to that beneficiary by the probate court. Because none of the proceeds was allocated to husband, it held that the claim costs related to him were not to be recoverable from the settlement.

116 Or App 67> Liberty argues that, under ORS 656.593, there is a single lien for the costs of providing benefits under the workers' compensation claim and that lien is against all the settlement proceeds from an action under ORS 656.593(1) after the distributions specified in ORS 656.593(1)(a) and (b).

Respondent argues that the Board properly exercised its discretion in determining a "just and proper distribution." ORS 656.593(3). She notes that decedent and her husband had not been living together for almost one year before the fatal injury and that decedent had filed for dissolution of the marriage. She argues that the children suffered the loss from their mother's death and it, therefore, is just that they receive all of the proceeds. The husband, she contends, suffered no loss and is entitled to no part of the settlement.

Allocation of damages among beneficiaries of a wrongful death action under ORS 30.030 is not the same as the distribution of the proceeds between the workers' compensation paying agency and the decedent's estate under ORS 656.593(3). The beneficiaries of a wrongful death action, ORS 30.020, are not the same as beneficiaries under the Workers' Compensation Act. ORS 656.204. The issue for the probate court, under ORS 30.030, is the amount that each beneficiary in the wrongful death action is to receive, according to that beneficiary's loss. Under ORS 656.593(3), the issue for the Board is what amount is just and proper for the paying agency to receive on its lien.

The Board, however, utilized the criteria under ORS 30.030 in deciding what is just and proper for the paying agency to receive. The Board essentially agreed with the probate court that husband had suffered no loss and should receive none of the proceeds from the settlement. From that conclusion, the Board held that it was therefore just and proper that Liberty not be paid the portion of its claim costs attributable to benefits paid to him. That puts the cart before the horse.

The structure of ORS 656.593 is that the paying agency's lien attaches to the gross proceeds of the settlement after the costs of obtaining it are subtracted, ORS 656.593(1)(a), and one-third of the balance is distributed to **<116 Or App 67/68>** the estate for the beneficiaries. ORS 656.593(1)(b). After those deductions, the paying agency is to receive what is just and proper toward payment of its lien and the remainder is distributed to the beneficiaries. The probate court may determine, under ORS 30.030, the allocation of the amounts distributed pursuant to ORS 656.593. The action of the probate court cannot determine the amount available for discharge of the paying agency's lien by allocating settlement proceeds to the beneficiaries designated under the Workers' Compensation Law.

Respondent argues that *Scarino v. SAIF*, 91 Or App 350, 755 P2d 139, *rev den* 306 Or 660 (1988), authorizes the probate court to distribute proceeds of a wrongful death action before the paying agency's lien is paid. That case is distinguishable. There, as a result of the decedent's death from an occupational disease, the personal representative of the estate brought a wrongful death action in federal district court pursuant to Washington law. A probate court in Washington distributed part of the judgment in the action to decedent's spouse, who was a beneficiary under Oregon's Workers' Compensation Act, and the

balance to persons who were not workers' compensation beneficiaries but were beneficiaries of the wrongful death action. We held that the part of the judgment payable to persons who were not workers' compensation beneficiaries was not subject to SAIF's lien for workers' compensation benefits, because that part of the judgment was not obtained by an action under ORS 656.593(1), i.e., it was not obtained by the worker's beneficiaries from a third party. See also *Robertson v. Davcol, Inc.*, 99 Or App 542, 783 P2d 43 (1989).

Here, the settlement was of an action brought for the benefit of persons who are workers' compensation beneficiaries. The distribution of settlement proceeds under ORS 656.593 is to the beneficiaries as a class, not to individuals. Individual allocation of damages is done by the probate court under ORS 30.030. There is a single lien and a single settlement.

The Board has some discretion to determine what is just and proper for the paying agency to receive, but that discretion must be exercised in the proper legal framework. <116 Or App 68/69> Because the Board used the wrong legal standard, we remand for reconsideration.

In the second assignment of error, Liberty contends that the Board incorrectly calculated the amount of its lien. Liberty argues that, under ORS 656.593(1)(c), the lien includes "the present value of its reasonably to be expected future expenditures for compensation." It essentially disputes the formula that the Board used in determining the present value of future benefits. Liberty and respondent presented expert testimony on the proper calculation. The Board accepted the testimony of respondent's expert. There is substantial evidence to support the determination.

Remanded for reconsideration of distribution; otherwise affirmed.

DURHAM, J., concurring in part, dissenting in part.

I agree with the majority that the board did not err in calculating the present value of future benefits that it authorized Liberty to accept. However, I disagree with the majority's construction of ORS 656.593.

ORS 656.593 provides, in part:

"(1) If the worker or the beneficiaries of the worker elect to recover damages from the employer or third person, notice of such election shall be given the paying agency 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 an employer or third person by the worker or beneficiaries shall be subject to a lien of the paying agency for its share of the proceeds as set forth in this section and the total proceeds shall be distributed as follows:

"(a) Costs and attorney fees incurred shall be paid, such attorney fees in no event to exceed the advisory schedule of fees established by the board for such actions.

"(b) The worker or the beneficiaries of the worker shall receive at least 33-1/3 percent of the balance of such recovery.

116 Or App 70> "(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. Such other costs include assessments for reserves in the Insurance and Finance Fund, but do not include any compensation which may become payable under ORS 656.273 or 656.278.

"(d) The balance of the recovery shall be paid to the worker or the beneficiaries of the worker forthwith. Any conflict as to the amount of the balance which may be retained by the paying agency shall be resolved by the board.

"(2) The amount retained by the worker or the beneficiaries of the worker shall be in addition to the compensation or other benefits to which such worker or beneficiaries are 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 agency is authorized to accept such a share of the proceeds as may be just and proper and the worker or the beneficiaries of the worker shall receive the amount to which the worker would be entitled for a recovery under subsections (1) and (2) of this section. Any conflict as to what may be a just and proper distribution shall be resolved by the board." (Emphasis supplied.)

The statute establishes the procedure for determining the extent to which a "paying agency," ORS 656.576, may receive a share of any sum recovered if a worker or the worker's beneficiary elects under ORS 656.578 to seek damages from the employer or a third person who has caused a compensable injury or death. Under ORS 656.580, "[t]he paying agency has a lien against the cause of action as provided by ORS 656.591 or 656.593 * * *." If the worker or a beneficiary sues and receives a damage award, subsection (1) grants the paying agency a lien against the award and designates the amount that it can recover. However, if the worker or the beneficiary settles the claim with the paying agency's consent, subsection (3) governs the paying agency's recovery. That section creates no lien on settlement proceeds. Instead, it authorizes the paying agency to "accept" a "just and proper share" of the settlement.

116 Or App 71> The majority disregards the significance of that terminology. The settlement of the third party action, with the paying agency's consent, extinguishes the cause of action and the lien. Thereafter, the paying agency must rely for its recovery either on an agreement that it may have reached with the claimant at the time of the settlement or, absent an agreement, on the Board's determination of a just and proper share. Neither potential source of recovery is a lien.

The majority analyzes this case as if it involves a paying agency's lien under ORS 656.593(1). That is incorrect. Respondent, with Liberty's concurrence,¹ settled the claim and invoked the Board's authority under ORS 656.593(3) to resolve a conflict as to what would be a just and proper distribution. The Board correctly determined that, in resolving the conflict,

¹ Liberty does not dispute the Board's finding that, as the paying agency, it approved the settlement. The majority correctly observes that Liberty makes no contention that the settlement approval is invalid because it is not in writing. 116 Or App at 66 n 1.

it is not required to calculate the paying agency's just and proper share as if it had a lien.²

The text of ORS 656.593(3) supports the Board's construction. The statute entitles the worker or the beneficiary to receive those sums that would be paid to a worker under the lien described in ORS 656.593(1) and (2). However, the statute makes no reference to a paying agency's statutory lien rights and entitles the agency only to a "just and proper" share. If the legislature had intended the result that Liberty <116 Or App 71/72> seeks, it would have drafted subsection (3) to grant the paying agency a lien on settlement proceeds or to entitle it to receive the same amount that it would receive through an ORS 656.593(1)(c) lien, just as it did for the worker or beneficiary. Its failure to do so demonstrates that the legislature did not intend to require the Board to calculate the agency's share as if it had a lien against the settlement.³

The majority's view that the Board reached its decision in the wrong legal framework is incorrect, because it assumes that the paying agency has a lien against the settlement proceeds. The error is not eliminated by the majority's acknowledgement that "[t]he Board has some discretion to determine what is just and proper for the paying agency to receive." 116 Or App at 68. The Board considered Liberty's contention that it should be reimbursed for all of its claim costs, including those related to husband, and rejected the claim. It designated a just and proper share and supported its decision with adequate findings and conclusions. Liberty received all that it is entitled under ORS 656.593(3).

I would affirm the Board's order in all respects.

² The Board relied on the probate court hearing, reports from and interviews with family members, coworkers, mental health counsellors and a babysitter and testimony by an attorney about the anticipated damage recovery and concluded:

"[A] distribution of settlement proceeds in equal portions to the two minor children with the surviving spouse receiving nothing represents an appropriate and reasonable apportionment commensurate with their respective financial and emotional losses resulting from decedent's death."

The Board explained why it confined Liberty's recovery of claim costs to the specific beneficiaries who shared in the third party settlement:

"To do otherwise would permit the paying agency to receive reimbursement for claim expenditures related to a particular beneficiary (surviving spouse) from other beneficiaries' (children) portions of a third party settlement. Since those other beneficiaries have not and will not realize any benefits from those claim costs, we would not consider such a proposed distribution to be just and proper."

The Board ruled out "gamesmanship" on respondent's part and followed the distribution approved by the probate court. The Board's conclusions are supported by findings that Liberty does not challenge.

³ The premise of the legislature's distinction is that a judgment awards all of the damages to which the claimant or beneficiary is entitled and, for that reason, the paying agency should be entitled to recover all expenditures for which it has a lien. ORS 656.593(1)(c). However, a settlement may represent a compromise of the third party claim and, for that reason, the Board may require a paying agency to accept a reduced sum as its just and proper share under ORS 656.593(3).

Cite as 116 Or App 76 (1992)

November 4, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Jimmie L. Leigh, Claimant.

PETER KIEWIT & SONS and **AETNA CASUALTY & SURETY COMPANY**, Petitioners,

v.

JIMMIE L. LEIGH, Respondent.

(WCB 90-08059; CA A70266)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 14, 1992.

Darren L. Otto, Portland, argued the cause for petitioners. On the brief were Allen W. Lyons and Scheminske & Lyons, Portland.

Donald M. Hooton, Eugene, argued the cause for respondent. With him on the brief was Malagon, Moore, Johnson & Jensen, Eugene.

Before Richardson, Presiding Judge, and Deits and Durham, Judges.

RICHARDSON, P.J.

Affirmed.

116 Or App 78> Employer seeks review of an order of the Workers' Compensation Board that awarded claimant 35 percent permanent partial disability. We affirm.

In 1987, claimant developed pulmonary problems after exposure to fumes while working as a welder for employer. Employer agrees that claimant is entitled to permanent partial disability benefits. The central issue is whether the Board erred in evaluating the extent of his disability.

A preliminary question is whether the Board erred by admitting a written vocational report offered by claimant. Employer argues that claimant did not give timely disclosure of an expert witness under OAR 438-07-016. The Board concluded that claimant offered only the report and that the rule only applies when a party calls an expert as a witness. We agree with that analysis.

Employer argues, alternatively, that the report is not admissible under ORS 656.287(1), because claimant did not receive it 10 days before the hearing. That statute provides:

"Where there is an issue regarding loss of earning capacity, reports from vocational consultants [regarding pertinent information] shall be admitted into evidence at compensation hearings, provided such information is submitted to claimant 10 days prior to hearing and that upon demand from the adverse party the person preparing such report shall be made available for testimony and cross-examination."

Claimant received the report less than 10 days before the hearing and disclosed it to employer after receiving it. The Board held, and we agree, that ORS 656.287(1) provides for admission of a report but does not mandate exclusion of reports received by a party less than 10 days before the hearing.

Employer's last argument about the report is that there was no foundation regarding the author's qualifications. The Board found that there was sufficient evidence. The report, signed by its author, identified him as a certified vocational consultant. Employer presented no contrary evidence and did not request that the author be made available <116 Or App 78/79> for cross-examination. We conclude that there was sufficient evidence of the expert's qualifications and that the Board did not abuse its discretion by admitting the vocational report.

The Board awarded claimant 35 percent permanent partial disability. Permanent disability is evaluated by applying the "standards" adopted by the Director pursuant to ORS 656.726(3)(f). In order for the Board to award unscheduled disability contrary to the standards, there must be clear and convincing evidence that the disability suffered was more or less than that prescribed by the standards. ORS 656.283(7).¹ Under the standards, claimant's pulmonary disability is rated at 21 percent. However, the Board found that, although he is capable of doing the same category of work as he did before the injurious exposure, he is unable to work in any environment where he would risk exposure to airborne pollutants. The Board concluded that that restriction limited claimant's employment options beyond that comprehended by the standards.

Employer argues that there is not clear and convincing evidence that claimant's impairment is greater than 21 percent. It argues that the vocational report should have been excluded and that the medical evidence is not free from confusion about claimant's impairment. Unscheduled permanent partial disability is based on loss of earning capacity, ORS 656.214(5), not on impairment. There was clear and convincing evidence to support the Board's finding that claimant's loss of earning capacity was more than that proscribed in the standards.

Affirmed.

¹ ORS 656.283(7) has since been amended. Or Laws 1990, ch 2, 20. Now the required quantum of proof is a preponderance of the evidence. The parties agree that the earlier version applies.

Cite as 116 Or App 161 (1992)

November 4, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Petition of
PAUL BROTHERS, INC., Petitioner,
v.

The filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE**, and
LIBERTY NORTHWEST INSURANCE CORPORATION, Respondents.
(89-08-045; CA A69352)

Judicial Review from Department of Insurance and Finance.

Argued and submitted January 27, 1992.

Philip F. Schuster, Portland, argued the cause for petitioner. With him on the brief was Roger F. Dierking, Portland.

Peter A. Ozanne, Portland, argued the cause for respondent National Council on Compensation Insurance. With him on the brief were Robert E. Joseph and Schwabe, Williamson & Wyatt, Portland.

Thomas H. Johnson, Portland, argued the cause and filed the brief for respondent Liberty Northwest Insurance Corporation.

John T. Bagg, Assistant Attorney General, Salem, argued the cause for Department of Insurance and Finance. 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.

DEITS, J.

Affirmed.

116 Or App 163> Petitioner Paul Brothers, Inc. (employer) seeks review of the Department of Insurance and Finance (DIF) order upholding respondent Liberty

Northwest's (Liberty) premium audit.¹ Employer argues that, for April 1, 1988, through April 1, 1989, Liberty erroneously included vacation pay in its calculation of employer's payroll. We affirm.

In September, 1989, pursuant to ORS 737.318, Liberty sent a final premium audit to employer assessing additional workers' compensation insurance premiums for the period in issue. Employer filed a petition with DIF seeking review of the assessment. After a hearing, DIF issued an order upholding the assessment. Employer seeks review of that order.

Employer is an Oregon corporation that does work as a subcontractor for the state and federal government. Under the federal and state Davis-Bacon Acts, 40 USC 276a, ORS 279.348 to ORS 279.365, employer is required to pay a prevailing wage rate that includes a specified fringe benefit package. It is the money paid to employees for the fringe benefit package that is the subject of this dispute. Employer assigns error to DIF's conclusion that Liberty properly included those funds as payroll in computing employer's premiums.

Employer first argues that DIF's conclusion that employer did not keep proper records to allow wages and vacation pay to be distinguished is not supported by substantial evidence. DIF found:

"Petitioner paid benefits directly to the employees according to the employees' election * * *. Petitioner then suggested that the employees use the funds for vacation reimbursement. During the period in dispute, petitioner did not maintain records that distinguished the amount paid as wages and the amount paid for vacation reimbursement. At a later period in time, petitioner did maintain records that <116 Or App 163/164> distinguished these amounts, and respondent Liberty allowed the vacation amounts to be exempted from workers' compensation premium assessment."

DIF's finding is supported by substantial evidence. Liberty's auditor testified that vacation pay was not identifiable from employer's records. Furthermore, employer's records that were admitted as evidence show that vacation pay was not segregated from other fringe benefits or wages. Employer argues that it designated all of the fringe benefits as vacation pay and that that was sufficient to allow Liberty to distinguish vacation pay from wages. However, even assuming an employer's designation of all fringe benefits as vacation pay would conclusively make those benefits vacation pay, DIF found that employer did not designate all fringe benefits as vacation pay. Rather, DIF found that employer only suggested to employees that it use the money as vacation pay. That finding is also supported by substantial evidence. Employer's president testified that the company suggested to employees that the benefits be used as vacation pay, but he admitted that the employees were free to use the benefits for things other than vacation.

Employer also argues that, even if the records it supplied to the auditor did not separate vacation pay sufficiently, Liberty had a duty to investigate beyond the records and that, if Liberty had done so, it would have discovered its policy that fringe benefits be used as vacation pay. However, in view of

¹ The National Council on Compensation Insurance (NCCI) is a respondent in this case. NCCI is a rating organization authorized to assist private insurance companies with workers' compensation insurance rates and risk classifications. See ORS 737.350 to ORS 737.560. Liberty conducted its audit in accordance with NCCI's guidelines. Appellant refers to both respondents in its assignments of error, but for clarity we refer only to Liberty.

our conclusion that DIF's finding that employer did not have such a policy is supported by substantial evidence, it is unnecessary to address this issue.

In its second assignment of error, employer argues that DIF erred in including the disputed funds as payroll because, as a matter of law, all Davis-Bacon Act benefits are exempt from premium assessment. However, we find no authority that, under these circumstances, DIF was required to conclude as a matter of law that all of the fringe benefits must be exempted from payroll. The pertinent statute at the time of the audit was ORS 656.005(20),² which defines "payroll" for purposes of a premium assessment as

116 Or App 165> "a record of wages payable to workers for their services and includes commissions, value of exchange labor and the reasonable value of board, rent, housing, lodging or similar advantage received from the employer. However, 'payroll' does not include overtime pay, vacation pay, bonus pay, tips, amounts payable under profit-sharing agreements or bonus payments to reward workers for safe working practices. Bonus pay is limited to payments which are not anticipated under the contract of employment and which are paid at the sole discretion of the employer. The exclusion from payroll of bonus payments to reward workers for safe working practices is only for the purpose of calculations based on payroll to determine premium for workers' compensation insurance, and does not affect any other calculation or determination based on payroll for the purposes of this chapter." (Emphasis supplied.)

Both the federal and state acts define "wages" to include fringe benefits. 40 USC 276a(b); ORS 279.348(1). Accordingly, the fringe benefits are included as payroll, unless they are exempted under ORS 656.005(20). Although subsection (20) exempts some fringe benefits, such as vacation pay, it does not exempt all fringe benefits. Because vacation pay was not segregated from other fringe benefits, DIF did not err in concluding that Liberty could properly include all fringe benefits in employer's payroll.

Employer also argues that Liberty's policy of including Davis-Bacon fringe benefits in payroll if they are paid directly to employees, but not assessing them if they are paid to third party trust funds, violates the insurance anti-discrimination statutes. ORS 737.310; ORS 746.015. In addition, employer argues that the policy violates Article I, section 20, of the Oregon Constitution and the Fourteenth Amendment. DIF did not address those issues, because it found that Liberty does not have such a policy. We conclude that DIF's finding is supported by substantial evidence. The evidence shows that Liberty's policy was to include Davis-Bacon fringe benefits in payroll whether they are paid directly to the employees or to third-party trust funds. Because of DIF's finding, it did not err in failing to address those arguments, and it is also unnecessary for us to do so.

Affirmed.

² That provision was renumbered in 1990 as ORS 656.005(21). Or Laws 1990, ch 2, 3. However, no substantive changes were made in the provision.

Cite as 116 Or App 166 (1992)November 4, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Petition of
SALEM DECORATING CENTER, INC., Petitioner,

v.

The filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE**, Respondent below,
and **SAIF CORPORATION**, Respondent.

(89-08-08; CA A68440)

Judicial Review from Department of Insurance and Finance.

Argued and submitted December 2, 1991.

J. Michael Alexander, Salem, argued the cause for petitioner. With him on
the brief was Burt, Swanson, Lathen, Alexander & McCann, Salem.Michael O. Whitty, Special Assistant Attorney General, Salem, argued the
cause for respondent. With him on the brief were Dave Frohmayer, Attorney
General, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Deits and Durham, Judges.

DEITS, J.

Affirmed.

116 Or App 168> Salem Decorating Center (employer) is an interior decorating firm that sells window, wall and floor coverings. It seeks review of an order by the Department of Insurance and Finance (DIF) upholding the results of two premium audits by its insurer, SAIF. We affirm.

During 1988 and 1989, SAIF provided workers' compensation insurance to employer. SAIF conducted audits of employer's workers' compensation premiums for the periods April 1, 1988, through March 31, 1989, and February 21, 1989, through September 30, 1989. SAIF assessed approximately \$18,000 in total additional premiums, based on its determination that some of the persons hired by employer to install its products were improperly characterized as independent contractors and that payments to those persons were improperly excluded from the subject payroll for the periods in question. Employer appealed to DIF, contesting DIF's jurisdiction over the matter and arguing that SAIF had improperly classified independent contractors as employees and that SAIF could not retroactively collect the premiums for a period when no claims were actually filed. DIF concluded that it had jurisdiction and upheld SAIF's billings. Employer seeks review.

Employer first argues that this is a contract dispute between it and SAIF and that DIF has no jurisdiction, because the statutes do not give DIF authority to act in this type of case. It contends that DIF's authority is limited to resolving rate disputes between insurers and employers.

DIF had authority to review this matter. ORS 737.318 specifically authorizes the director of DIF to develop and administer a premium audit program and appeal process:

"(1) A workers' compensation insurer shall maintain a premium audit program to aid in achieving equitable premium charges to Oregon employers and for the collection of credible state-wide data for ratemaking.

"(2) The director shall prescribe by rule a premium audit program system for workers' compensation insurance.

"(3) The premium audit system shall include provisions for:

116 Or App 169> "(a) Employer education of the audit reporting function of the rating system;

"(b) A continuous test audit program providing for auditing of all insurers;

"* * * * *

"(d) An appeal process pursuant to ORS 737.505 for employers to question the results of a premium audit * * *."

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."

Under that authority, the director has adopted administrative rules governing the conduct of premium audits, OAR 836-43-110, and the appeal process. OAR 836-43-170. The rules include guides for developing audit procedures, OAR 836-43-115, and OAR 836-43-110(3) specifically governs situations where the insurer must decide if workers are employees or independent contractors:

"In addition to the requirements of Section (2) of this rule, if the premium audit billing is based in whole or part on a determination by the insurer that one or more persons are employees rather than an independent contractor, the insurer must also include with respect to each such person an explanation of that determination. The explanation must name the person, designate or describe the position or tasks for which the person is determined to be an employee and give reasons for the determination."¹

The statutes, and the rules implementing them, are clear that DIF's jurisdiction over premium audits is not limited to resolving rate disputes.

Employer also argues that, because this is a contract dispute, it is entitled to a jury trial and that, therefore, because DIF's process does not provide for a jury trial, DIF lacked authority to resolve this dispute. However, the right to a jury trial exists only "'in the classes of cases wherein the right was customary at the time the constitution was adopted' * * * or 'cases of like nature' * * *." *Cornelison v. <116 Or App 169/170> Seabold*, 254 Or 401, 405, 460 P2d 1009 (1969) (citations omitted); see also *Molodyh v. Truck Insurance Exchange*, 304 Or 290, 744 P2d 992 (1987). As the court explained in *Cornelison*, it is the particular issue in the proceeding rather than the controversy as such that dictates whether there is a right to a jury. 254 Or at 406. While there may be contract issues between the parties here that could be resolved in some other proceeding, the issue in this proceeding involves the resolution of a premium audit dispute under a statutory procedure that was established by the legislature in 1987. Employer is not entitled to a trial by jury to resolve this dispute.

In its next assignment of error, employer contends that the referee erred in placing the burden of proof on it. ORS 183.450(2) provides that "[t]he burden of presenting evidence to support a fact or position in a contested case rests upon the proponent of the fact or position." As the Supreme Court has explained:

¹ The current version of the rule, renumbered subsection (4), effective May 9, 1990, is substantially the same, with only minor variations in the text.

"The general rule is that the burden of proof is upon the proponent of the fact or position, the party who would be unsuccessful if no evidence were introduced on either side. See, Oregon Evidence Code Rules 305-307 (replacing ORS 41.210); ORS 183.450(2)." *Harris v. SAIF*, 292 Or 683, 690, 642 P2d 1187 (1982). (Footnote omitted.)

Because employer was the party seeking redress before DIF and whose position would be defeated if no evidence were introduced on either side, it had the burden to prove that SAIF was wrong in including the payments to the installers in its subject payroll. See *Prem Singh & Assoc. v. Natl. Council on Comp. Ins.*, 111 Or App 624, 627, 826 P2d 120, rev den 313 Or 300 (1992).

Employer next contends that DIF erred in concluding that its installers are subject employees, as opposed to independent contractors.² A worker or subject employee is one who is "subject to the direction and control of an employer." ORS 656.005(27).³ An employer is one who has <116 Or App 170/171> "the right to direct and control the services of any person." ORS 656.005(13). We have held that the principal factors in applying the right to control test are:

"(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*, 95 Or App 269, 272, 769 P2d 215 (1989).

DIF concluded that employer had the requisite right to control its installers and made these findings in support of that conclusion:

"The record clearly shows that [employer] maintained the fundamental control over its installers by:

- "(1) Initially procuring the contract with the customer;
- "(2) Initially choosing the installer;
- "(3) Instructing the installer on where to work and when the work had to be completed;
- "(4) Supplying the primary material necessary for performance;
- "(5) Paying the installer directly through Petitioner;
- "(6) Maintaining the right to remove the installer from a job and to replace the installer;
- "(7) Maintaining the right to withhold pay if a job was not completed properly."

We review DIF's order for substantial evidence to support its findings, *Power Master, Inc. v. National Council on Comp. Ins.*, 109 Or App 296, 301, 820 P2d 459 (1991), and to determine whether those findings support its conclusion as a matter of law. ORS 183.482; see also *Castle Homes, Inc. v. Whaite*, supra, 95 Or App at 272. Employer characterizes its relationship with its installers as that of "prime contractor" and "subcontractor," arguing that

² Because the audit periods in this case are before October, 1989, we do not consider the effect of amendments to the statutes relating to independent contractors. Or Laws 1989, ch 762; see ORS 701.025.

³ Subsection (27) of ORS 656.005 has been renumbered subsection (28). Or Laws 1990, ch 2, 3.

"the evidence clearly reveals that these workers were all truly independent, furnishing their own tools, working for other persons, doing the job according to their own techniques and methods, being held personally responsible for inadequate performance, and generally paid by the job or the piece. The evidence also reveals that this manner of doing business was typical in the industry."

116 Or App 172> We conclude that DIF's findings are supported by substantial evidence and that those findings support DIF's conclusion that the workers in question were subject employees. The evidence shows that employer had some right to control the installers. After negotiating a contract with a customer, it hired a person or persons to install its products, giving the job description, location and deadline. Employer provided "decorating expertise" and coordinated completion of the job. It also had the right to monitor the progress of the work to see if the installer was doing an adequate job. If the work was not satisfactorily done, the installer had to cure the defect at his or her own expense. Employer had a strong interest in controlling the manner and method of the installer's work. See *Collins v. Anderson*, 40 Or App 765, 769, 596 P2d 1001 (1979).

As to the method of payment, the installers received payment from employer, not the customer, and were paid by the piece, job, hour or bid. As we explained in *Henn v. SAIF*, 60 Or App 587, 592, 654 P2d 1129 (1982), rev den 294 Or 536 (1983):

"To the extent that [a manner of payment] indicates continuing service, it suggests employment; to the extent that it lessens an employer's interest in the details of how the employe spends her time, it has been said to suggest an independent contractor relationship."

Although the evidence shows that there was a continuing relationship, there was no evidence of a written employment contract. This factor is not determinative here. The factor of furnishing the equipment is also neutral. Both employer and its installers furnished some equipment necessary to complete the job.

Finally, we consider whether employer had the right to fire the installers. DIF found that, if a customer was dissatisfied with the installer's job, employer could withhold the installer's pay until the problem was remedied. Employer also had the right to terminate the installer before the job was completed and to replace that installer with another and could withhold future work from the installer. We conclude that DIF's findings are supported by substantial evidence and that it did not err as a matter of law in concluding that **<116 Or App 172/173>** employer's installers were subject workers for purposes of calculating workers' compensation insurance premiums.

In its last assignment of error, employer contends that DIF erred in holding that SAIF could retroactively collect premiums for subject workers when none of those additional workers made a claim for compensation during the time periods covered by the premiums. The premium employer paid before the audit was payment for the *estimated* risk that SAIF was to insure, not for actual injuries. See *Mock et al v. Glens Falls Indem. Co.*, 210 Or 71, 79 n 2, 309 P2d 180 (1957). Had the results of the audit shown that employer paid too much, it would have been entitled to money back, regardless of how many claims had been filed during the subject period. DIF did not err in allowing the collection of premiums.

Affirmed.

Cite as 116 Or App 295 (1992)

November 12, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Martin J. McKeown, Claimant.

MARTIN J. McKEOWN, Petitioner,

v.

SAIF CORPORATION and MARTIN J. McKEOWN, P.C., Respondents.
(90-18674; CA A72877)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 4, 1992.

Edward J. Harri, Eugene, argued the cause for petitioner. With him on the brief were Donald M. Hooton and Malagon, Moore, Johnson & Jensen, Eugene.

Steven Cotton, Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

ROSSMAN, J.

Reversed and remanded for acceptance of claim.

116 Or App 297> Claimant, an attorney, seeks review of an order of the Workers' Compensation Board holding that an injury that he sustained on his way to a legal education conference is not compensable.

The facts are undisputed. Claimant practices law as a sole practitioner, with an emphasis on workers' compensation. He is the sole shareholder in employer, and the corporation has elected workers' compensation coverage for him. He regularly works evenings and weekends at home or at the office. During those times, he often meets with clients or contacts them by telephone. Although his main office is in Eugene, he has clients in other parts of the state, including Portland, where he shares office space with another attorney. For convenience and to save on hotel costs, employer rents an apartment for claimant to use while he is in Portland.

Claimant frequently rides his bicycle to work or to meet clients. He uses a cellular telephone to call clients or other attorneys from his automobile or locations other than the office or his home. The corporation's by-laws require claimant to attend continuing legal education programs. The corporation pays him a salary and an additional amount after payment of overhead, but does not pay him separately or reimburse him for his time or expenses for attending CLE's.

On Friday, July 20, 1990, claimant drove to Portland so that he could attend a CLE program on Saturday morning. On Friday evening, he read recent legislation in preparation for the CLE and made several business calls.

Claimant rode his bicycle to the CLE on Saturday morning. He carried his telephone, which he intended to use to telephone clients before the meeting began. While riding down Front Street, his bicycle tire got caught in the pavement, and he lost his balance and fell to the ground. He injured his head, knee and left hip. Claimant called his daughter on his portable telephone, and she came and took him to the hospital, where he underwent treatment for a broken hip.

SAIF denied the claim on the ground that the injuries did not occur in the course of employment. The referee <116 Or App 297/298> and the Board upheld the denial, finding that claimant did not attend the CLE as a part of his employment

but, rather, to maintain the qualifications for his employment, and that any risk associated with attending the meeting was his own rather than employer's.

Claimant directed his own activities and decided when and where he would work. The Board's opinion relies on technical employment distinctions and speaks in terms of what "employer" required of claimant, thereby attempting to distinguish activities required by the employment from those that claimant chose for himself personally. The Board's order turns on its conclusion that CLE attendance was not a requirement of the employment, but only a prerequisite or condition to claimant's employment as an attorney, and, therefore, that any risk was personal to claimant and not related to employment. CLE attendance was a requirement of his employment, however, even if claimant, as president of the corporation, directed himself to attend it.

Applying the test of "work-connectedness" established in *Rogers v. SAIF*, 289 Or 633, 616 P2d 485 (1980), and the factors in *Mellis v. McEwen, Hanna, Grisvold*, 74 Or App 571, 703 P2d 255, rev den 300 Or 249 (1985), we conclude that the claim is compensable, even in the face of the technical distinctions of employer and employee. The uncontroverted evidence is that claimant directed himself to go to Portland to conduct business and to attend the CLE and that he was injured on his way to the CLE. Although claimant was not paid separately for his attendance at the CLE, it was contemplated that, as a part of his regular work and within his monthly salary, he would work outside the office and attend such programs. The fact that the injury occurred off employer's premises is not significant, in view of the fact that claimant had travelled to and was in Portland as a part of his work at employer's direction and, at the time of the injury, was on his way to a program for employer's benefit. Accordingly, on the undisputed facts, as a matter of law, claimant was injured in the course of his employment, and the injury is compensable.

Reversed and remanded for acceptance of the claim.

Cite as 116 Or App 333 (1992)

November 12, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Robin R. Oliver, Claimant.

ROBIN R. OLIVER, Petitioner,

v.

NORSTAR, INC., and FIRE & CASUALTY INSURANCE CO., Respondents.
(90-15596; CA A71720)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 19, 1992.

Kevin N. Keaney, Portland, argued the cause for petitioner. With him on the brief were Robert K. Udziela and Pozzi, Wilson, Atchison, O'Leary & Conboy, Portland.

Howard R. Nielsen, Portland, argued the cause for respondents. With him on the brief was Beers, Zimmerman, Rice & Nielsen, Portland.

Before Buttler, Presiding Judge, and Rossman and De Muniz, Judges.

DE MUNIZ, J.

Affirmed.

116 Or App 335> Claimant seeks review of an order of the Workers' Compensation Board that affirmed the referee's award of a penalty under ORS 656.262(10), as amended by Or Laws 1990 (Spec Sess), ch 2, 15, for employer's failure to pay temporary total disability, but reversed the referee's decision that claimant is entitled to attorney fees under ORS 656.382.

While working for employer, claimant, a veterinary technician, contracted psittacosis, a disease carried in parrot feces. The claim was accepted, and medical benefits and time loss were paid. The claim was closed.

Claimant's symptoms returned, and she sought treatment and benefits for time lost from work. Employer denied the claim, but a referee ordered it accepted and processed. Employer requested a determination order. Subsequently, the Evaluation Section requested employer to schedule an examination by an attending physician. Employer did not do that; nor did it pay claimant the time loss to which she was entitled.

The referee found that employer acted unreasonably when it failed to comply with the order requiring acceptance and processing of the claim and when it refused to pay benefits for temporary total disability. It assessed a penalty under ORS 656.262(10) for "unreasonable claims processing" and attorney fees under ORS 656.382(1). ORS 656.262(10) provides:

"(a) If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amount then due. Notwithstanding any other provision of this chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount described in this subsection. The entire additional amount shall be paid to the worker if the worker is not represented by an attorney. If the worker is represented by an attorney, the worker shall be paid one-half the additional amount and the worker's attorney shall receive one-half the additional amount, in lieu of an attorney fee. The director's action and review thereof shall be subject to ORS 183.310 to <116 Or App 335/336> 183.550 and such other procedural rules as the director may prescribe.

"(b) When the director does not have exclusive jurisdiction over proceedings regarding the assessment and payment of the additional amount described in this subsection, the provision for attorney fees provided in this subsection shall apply in the other proceeding."

ORS 656.382(1) provides:

"If an insurer or self-insured employer refuses to pay compensation due under an order of a referee, board or court, or otherwise unreasonably resists the payment of compensation, the employer or insurer shall pay to the claimant or the attorney of the claimant a reasonable attorney fee as provided in subsection (2) of this section. To the extent an employer has caused the insurer to be charged such fees, such employer may be charged with those fees."

The Board reversed the award of attorney fees, reasoning that the conduct for which the penalty was assessed under ORS 656.262(10) could not also form the basis for an award of attorney fees under ORS 656.382.

We agree with the Board that, when the misconduct is such that a penalty may be assessed under ORS 656.262(10), no fees are available under ORS 656.382(1). See *Martinez v. Dallas Nursing Home*, 114 Or App 453, 836 P2d 147 (1992). When, however, the employer's conduct would not subject it to a penalty, but is of the type that would give rise to an assessment of attorney fees under ORS 656.382(1), attorney fees may be awarded. Here, a penalty is assessable under ORS 656.262(10) for employer's unreasonable refusal to pay

disability benefits; accordingly, attorney fees are not available with regard to that conduct.

Claimant contends that the unreasonable refusal to process the claim encompassed not only the failure to pay time loss, but two acts of misconduct for which a penalty is not available under ORS 656.262(10) and for which attorney fees should be available under ORS 656.382(1). The referee found that the failure to process the claim included an unreasonable request for claim closure and a refusal to schedule an examination that had been requested by the Evaluation Section. We conclude that substantial evidence supports the Board's finding that those circumstances fall within the <116 Or App 336/337> misconduct of not processing the claim, for which a penalty has been assessed. Accordingly, we agree with the Board that attorney fees are not available under ORS 656.382.

Affirmed.

Cite as 116 Or App 398 (1992)

November 18, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Bettie R. Baxter, Claimant.

BETTIE R. BAXTER, Petitioner,

v.

MJB INVESTORS and SAIF CORPORATION, Respondents.

(WCB 90-19239, 90-19240; CA A70737)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 8, 1992.

Martha C. Evans, Eugene, argued the cause for petitioner. With her on the brief was DePaolis, Evans, Shepard & Vallerand, Eugene.

Michael O. Whitty, Special Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Deits and Durham, Judges.

RICHARDSON, P.J.

Affirmed.

116 Or App 400> Claimant seeks review of an order of the Workers' Compensation Board that dismissed her request for Board review of the referee's decision because it was untimely. We affirm.

Claimant filed a petition for review of SAIF's denial of her claim. The referee upheld the denial. Claimant filed a "Petition for Judicial Review of Workers' Compensation Board" in the Court of Appeals on April 29, 1991. We dismissed the petition, because the Court of Appeals does not have jurisdiction to review a decision of the referee on a claim. Claimant then filed a request for review with the Board on June 7, 1991. SAIF moved to dismiss the request, because it was untimely. The motion was served on claimant's counsel on June 21, 1991, and the Board allowed the motion on June 28, 1991.

Claimant first argues that the Board allowed SAIF's motion to dismiss without giving her an opportunity to respond, as required by OAR 438-11-025 and OAR 438-06-045. The first rule provides essentially that filing a motion tolls the time for the next event in the process; the second relates to motions filed before the referee and provides that 10 days shall be allowed for written response. Claimant argues that the two rules, when read together, allowed her 10 days to file a written response. Because SAIF's motion was allowed 7 days after it was filed, she says that the rules were violated.

The rules, by their terms, relate to proceedings before the referee. It is doubtful that they control comparable procedures before the Board. Claimant does not cite any rules of the Board but argues that there is an inference from the text of the rules that the Board will allow 10 days for a written response to a motion. From that premise, she summarily concludes that the due process of law mandates that time for response. The Board did not violate the rules.

She also argues that due process requires an opportunity to respond and present legal arguments before the motion is denied. She does not identify, other than by using the term "due process," the source of her contention. We need not decide if there was a constitutional infirmity in the proceedings, if that is the sense of her contention, because <116 Or App 400/401> claimant did submit materials relating to SAIF's motion. She incorporated an affidavit of her attorney with the petition for review. The affidavit set forth the reasons that the petition was late and included the legal basis that she offered for accepting the untimely petition. Claimant has not established her contention that she was denied "due process."

Claimant argues, alternatively, that the petition for review filed with the Court of Appeals satisfied the statutory requirements to invoke the jurisdiction of the Board. She says that a copy of the petition to this court was mailed to SAIF and to the Board and that that is sufficient. That petition, however, was addressed by caption and by content to the Court of Appeals and sought review of a non-existent order of the Board. A copy was mailed by regular mail to the Board. We decline to hold, as claimant suggests, that as a matter of law the Board acquired jurisdiction of the case by receiving a copy of the petition filed in this court.

The Board held that the request for review filed with it by claimant on June 7, 1991, was untimely and claimant does not dispute that holding. There was no other request for review properly filed, and the Board did not have jurisdiction.

Affirmed.

Cite as 116 Or App 405 (1992)

November 18, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
 In the Matter of the Complying Status of Chris McMurtry, dba McMurtry Video
 Productions, Employer, and
 In the Matter of the Compensation of Pierre R. Ferland, Claimant.

PIERRE R. FERLAND, Petitioner,

v.

McMURTRY VIDEO PRODUCTIONS, CHRIS McMURTRY, SAIF CORPORATION and
 DEPARTMENT OF INSURANCE AND FINANCE, Respondents.

(WCB 89-01238 & 89-01239; CA A70403)

Judicial Review from Workers' Compensation Board.

Argued and submitted February 24, 1992.

Thomas M. Sheridan, Portland, argued the cause for petitioner. On the brief were Stafford J. Hazelett and Davis & Bostwick, Portland.

Todd A. Zilbert, Portland, argued the cause for respondents Murtry Video Productions and Chris McMurtry. With him on the brief were Craig C. Murphy and Wood Tatum Wonacott & Landis, Portland.

Michael O. Whitty, Special Assistant Attorney General, Salem, waived appearance for SAIF Corporation and Department of Insurance and Finance.

Before Richardson, Presiding Judge, and Deits and Durham, Judges.

RICHARDSON, P.J.

Affirmed.

116 Or App 407> Claimant seeks review of an order of the Workers' Compensation Board that dismissed his appeal of an order of the Director of the Department of Insurance and Finance (DIF). The Board held that it did not have jurisdiction of the appeal. We affirm.

Claimant was injured while working as a cameraman for respondent McMurtry Video Productions (employer). He filed a claim with DIF, because employer was a noncomplying employer, ORS 656.054, and the claim was assigned to SAIF for processing. ORS 656.054(1). DIF issued a proposed order declaring that employer was a noncomplying employer. It requested a hearing before a Division referee. ORS 656.740(3). The referee issued an order declaring that claimant was a subject worker and that employer is a noncomplying employer. The referee rejected claimant's request for attorney's fees paid by employer. That order was a final order of DIF. ORS 656.740(4)(a).

Both employer and claimant appealed to the Board, but employer withdrew its appeal. The Board held that review of DIF's final order is only by the Court of Appeals under ORS 183.482 and that the Board did not have jurisdiction of claimant's appeal. We agree.

Unless an order declaring a person to be a noncomplying employer is contested at the same hearing as a matter concerning a claim, it is an order in a contested case, subject to judicial review under ORS 183.482. ORS 656.470(4)(c). The hearing before the referee on DIF's proposed order concerned only the status of employer. The hearing did not concern claimant's claim, which was being processed by SAIF under ORS 656.054(1). The Board properly dismissed claimant's appeal.

Affirmed.

Cite as 116 Or App 427 (1992)

November 18, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Babette Stone, Claimant.

BABETTE STONE, Petitioner,

v.

WHITTIER WOOD PRODUCTS and SAIF CORPORATION, Respondents.
(90-06254; CA A70323)

Judicial Review from Workers' Compensation Board.

Argued and submitted December 16, 1991.

Edward J. Harri, Eugene, argued the cause for petitioner. On the brief were Donald M. Hooton and Malagon, Moore & Johnson, Eugene.

Steve 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 Richardson, Presiding Judge, and Deits and Durham, Judges.

DEITS, J.

Affirmed.

116 Or App 429> Claimant seeks review of an order of the Workers' Compensation Board denying her temporary partial disability. We affirm.

Claimant suffered a compensable injury to her arm in February, 1989. At that time, she was earning \$6.97 per hour. In March, 1989, she was released to light-duty work and, in August, was given a raise to \$7.48. In May, she voluntarily enrolled in an alcohol treatment program. Although her alcohol problem had not affected her work performance, she did have an absenteeism problem, which was due in part to her alcohol problem. At the same time that

she enrolled in the treatment program, she also entered a "last chance agreement" with employer, promising to abstain from the use of alcohol or drugs and to comply with the treatment program. Claimant again began abusing alcohol in July, 1989, and was terminated from the treatment program in September.

On August 16, claimant had arm surgery. She returned to modified work on August 23 and was allowed to remain at her previous pay of \$7.48 per hour, even though she was assigned to a lower-paying job. On September 11, employer terminated her for absenteeism and failure to adhere to the terms of the last chance agreement. She was declared medically stationary on December 4, 1989. SAIF paid time loss up to September 11, but refused to pay it after termination.

Claimant requested a hearing, contending that she was entitled to TPD from the date of her termination September 11, 1989, to her medically stationary date, December 4, 1989. The referee determined that, under *Safeway Stores v. Owsley*, 91 Or App 475, 756 P2d 48 (1988), claimant was not entitled to TPD after her termination. The Board adopted the referee's order on review.

Under *Owsley*, if an injured worker returns to work earning the same or higher wages than before the injury and is terminated for reasons not related to the injury, the worker is not entitled to temporary benefits after the termination date. 91 Or App at 479. When claimant was terminated, she was earning a higher wage than at the time of the injury, and <116 Or App 429/430> her termination was not based on her injury. Accordingly, as the Board concluded, she was not entitled to TPD.

Claimant argues, however, that the *Owsley* rule should not apply if the termination was unlawful. She contends that she was discharged because of her alcohol problem, in violation of ORS 659.425(1)¹ and public policy, and that, before the Board could determine her entitlement to compensation, it was first required to determine whether she was unlawfully discharged.

We do not agree that the Board must first determine whether a termination is in conformance with statutory provisions other than the Workers' Compensation Act before it can determine a claimant's entitlement to workers' compensation benefits. So long as a termination is not for reasons related to the injury and the worker is earning wages equal to or greater than those received at the time of the injury, there is no entitlement to temporary benefits after the termination date. *Safeway Stores v. Owsley*, *supra*. If claimant is correct that her termination was in violation of ORS 659.425, she may be entitled to remedies that are available under that statutory scheme. See *Welch v. Champion International Corp.*, 101 Or App 511, 791 P2d 152 (1990).²

Claimant also argues that she is entitled to TPD after the termination, because her earning capacity at that time <116 Or App 430/431> was not equal to or greater than her earning capacity at the time of the injury. She acknowledges that her wages when she was terminated were greater than her wages in

¹ ORS 659.425(1) provides that it is unlawful for an employer to dismiss an employee because

"(a) An individual has a physical or mental impairment which, with reasonable accommodation by the employer, does not prevent the performance of the work involved;

"* * * * *

"(c) An individual is regarded as having a physical or mental impairment."

February, the time of her injury, but contends that that does not matter, because employer was paying her more than other workers in the same position. Claimant's argument is without merit. The Board properly considered her actual wages at the time of the termination.

Affirmed.

² The referee's opinion, which the Board adopted, says:

"Claimant argues that she was discharged because of her disability and not because of any impairment on the job. She argues that discharge because of disability is against public policy, and that an unlawful discharge should not trigger the Owsley rule. I am inclined to agree that the standard for termination *should* be impairment on the job rather than consumption of an intoxicating substance off the job. I do not find that the argument claimant is making here *is presently* the law. This is not the forum to create new law in this matter." (Emphasis in original; footnote omitted.)

The referee's comment as to the present state of the law was *dictum*, and we express no opinion as to its correctness.

Cite as 116 Or App 448 (1992)

November 18, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Robert W. McDonald, Claimant.

ROSEBURG FOREST PRODUCTS, Petitioner,

v.

ROBERT W. McDONALD, Respondent.

(90-01111; CA A69668)

Judicial Review from Workers' Compensation Board.

Argued and submitted April 17, 1992.

Adam T. Stamper, Medford, argued the cause for petitioner. With him on the brief was Cowling & Heysell, Medford.

Karsten H. Rasmussen, Eugene, argued the cause for respondent. On the brief were Allison Tyler and Rasmussen & Henry, Eugene.

Before Richardson, Presiding Judge, and Deits and Durham, Judges.

DEITS, J.

Affirmed.

116 Or App 450> Employer seeks review of an order by the Workers' Compensation Board awarding claimant penalties and attorney fees for employer's failure to pay time loss benefits pursuant to a determination order. We affirm.

A referee overturned employer's denial of claimant's aggravation claim and remanded the claim to employer for "acceptance, processing and payment of benefits under Oregon Workers' Compensation Law." Employer did not appeal the referee's order, but issued a letter acknowledging that the claim was reopened and denying time loss benefits on the ground that claimant had withdrawn from the work force. Claimant sought a hearing on employer's refusal to pay time loss. Meanwhile, employer sought claim closure, and a determination order was issued, awarding claimant 40 percent PPD and ordering employer to pay time loss for the period that employer had refused to pay, February 15 through May 1, 1989. After that order, employer again refused to pay time loss, and both parties requested a hearing. The referee held that, although claimant was not substantively enti-

bled to time loss benefits for the period in question, because he had withdrawn from the work force, employer, nevertheless, was required to pay pending appeal of the order. Employer appealed to the Board.¹

Before the Board issued its decision on appeal of the referee's order, claimant requested a second hearing on employer's failure to pay the time loss ordered by the first referee. The second referee concluded that claimant was entitled to penalties and attorney fees:

"The filing by the employer of a request for Board review does not stay the mandate of a Referee's Order concerning payment of time loss compensation. ORS 656.313(1); (4). I disagree with the employer's characterization of the Determination Order and the Referee's Order as entered 'without jurisdiction.' Both were within the jurisdiction of the respective adjudicators to enter. Either may be erroneous, but neither is void as a result, merely reversible. The employer <116 Or App 450/451> was obligated to obey the Referee['s] Order. * * * [A]n attorney fee may be assessed where an employer 'refuses to pay compensation due under an Order of a referee.'"

The Board upheld the second referee's July, 1990, order. Employer seeks review of that decision.

ORS 656.262(10)(a)² provides, in part:

"If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due plus any attorney fees which may be assessed under ORS 656.382."

ORS 656.382(1) provides:³

"If an insurer or self-insured employer refuses to pay compensation due under an order of a referee, board or court, or otherwise unreasonably resists the payment of compensation, the employer or insurer shall pay to the claimant or the attorney of the claimant a reasonable attorney fee as provided in subsection (2) of this section. To the extent an employer has caused the insurer to be charged such fees, such employer may be charged with those fees."

ORS 656.313(1)⁴ provides:

"Filing by an employer or the insurer of a request for review or court appeal shall not stay payment of compensation to a claimant."

¹ The Board eventually upheld the referee's order, concluding that claimant was procedurally entitled to be paid time loss. That order is not an issue in this review.

² The statute has since been amended. Or Laws 1990, ch 2, 15. See *Oliver v. Norstar, Inc.*, 116 Or App 333, ___ P2d ___ (1992).

³ The statute has since been amended. Or Laws 1990, ch 2, 28. See *Oliver v. Norstar, Inc.*, *supra*, n 2.

⁴ The statute has since been amended. Or Laws 1990, ch 2, 23.

Employer argues that, even though claimant was found to be procedurally entitled to time loss, the award of time loss cannot be "compensation" for the purposes of ORS 656.313 and there can be no assessment of penalties under ORS 656.262 and of attorney fees under ORS 656.382 for failure to pay, because he did not have a substantive right to compensation. Employer relies on *Georgia-Pacific v. Hughes*, 305 Or 286, 751 P2d 775 (1988), and *Hunter v. Teledyne Wah Chang*, 91 Or App 374, 755 P2d 146, rev'd on other grounds <116 Or App 451/452> 306 Or 659, 761 P2d 926 (1988), which hold that, because it was ultimately determined that the claimants were not entitled to compensation, the employers could not be penalized for failing to pay that compensation. Those cases are distinguishable, because they involved the question of whether interim temporary disability payments are required pending an employer's acceptance or denial of a claim. See also *Randall v. Liberty Northwest Ins. Co.*, 107 Or App 599, 813 P2d 1120 (1991).

This case concerns whether an employer must make time loss payments required under a determination order pending an appeal of that order. In *Georgia-Pacific v. Piowar*, 305 Or 494, 753 P2d 948 (1988), the court held that, regardless of whether a claim is ultimately found to be compensable, if a claimant is awarded compensation by a determination order, payment "must continue until a referee or appellate body orders otherwise." 305 Or at 504.

Employer also argues that the Board erred in assessing a penalty and attorney fees, because the determination order on which the penalties was based was void. However, even if the earlier determination order was erroneous, as noted in the Board's explanation of its decision, it was not void. The Board did not err in imposing a penalty and attorney fees.

Affirmed.

Cite as 116 Or App 485 (1992)

November 18, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Petition of

BRUER'S CONTRACT CUTTING, Petitioner,

v.

The Filings of the **NATIONAL COUNCIL ON COMPENSATION INSURANCE** and SAIF CORPORATION, Respondents.
(89-03-16; CA A68831)

Judicial Review from Department of Insurance and Finance.

Argued and submitted December 2, 1991.

Ronald B. Terzenbach, Eugene, argued the cause for petitioner. With him on the brief were Daniel M. Holland and Loomis & Holland, Eugene.

Peter A. Ozanne, Portland, argued the cause for respondent National Council On Compensation Insurance. With him on the brief was Schwabe, Williamson, Wyatt, Portland.

Michael O. Whitty, 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.

Reversed and remanded for proceedings not inconsistent with this opinion.

116 Or App 487> Petitioner seeks review of a Department of Insurance and Finance (DIF) final order requiring petitioner to pay additional workers'

compensation premiums. The order concluded that SAIF is not estopped from collecting the extra premiums. We reverse and remand.

SAIF contends that petitioner should pay the additional premiums, because petitioner erroneously failed to include truck rent in calculating its employees' wages. Wages affect the workers' compensation insurance premium. Petitioner paid its employees a salary and \$20 per day as truck rent, because they often drove up to 50 miles in their own vehicles to reach work sites. Petitioner paid the rent regardless of the loggers' actual expenses, which an industry expert estimated at about \$30 daily, and regardless of whether they drove their own trucks or shared rides.¹ It kept separate records for wages and truck rent. Petitioner excluded the truck rent from salary when calculating its workers' compensation premium. SAIF had informed petitioner that the practice was permissible but reversed its position after a premium audit and assessed an additional premium for April 1, 1986, through March 31, 1988.

We determine two preliminary matters before proceeding to the merits. First, relying on ORS 183.460,² petitioner assigns error to DIF's failure to issue a proposed order before issuing a final order. In *Bob Wilkes Falling v. National Council on Comp. Ins.*, 108 Or App 453, 455, 816 P2d 1172, rev den 312 Or 527 (1991), we held that ORS 183.460 did not require an agency to issue a proposed order before issuing a final order, so long as the issuer has reviewed the entire <116 Or App 487/488> record. The final order here states that its issuer had reviewed the record. That satisfies ORS 183.460.

Second, in a cross-assignment of error, respondents argue that DIF erred in ruling that issue preclusion does not bar it from considering whether SAIF is estopped from claiming that truck rent should be included in the payroll. DIF had determined in a 1988 order that truck rent should be included as compensation when calculating petitioner's premium. We reject the argument for two reasons. First, in *Drews v. EBI Companies*, 310 Or 134, 139, 795 P2d 531 (1990), the court said that

"issue preclusion * * * precludes future litigation on a subject issue only if the issue was 'actually litigated and determined' in a setting where 'its determination was essential to' the final decision reached."

The parties did not litigate, and DIF did not determine, petitioner's estoppel claim in the 1988 proceeding.

Second, *Drews* held that a "statutory scheme of remedies may expressly contemplate that successive proceedings may be brought, notwithstanding the finality of the first proceeding." 310 Or at 143. DIF reviewed ORS 737.318³ and concluded:

¹ Petitioner testified that he chose \$20 on the basis of estimates that each worker drove his own truck 60 percent of the time.

² ORS 183.460 provides:

"Whenever in a contested case a majority of the officials of the agency who are to render the final order have not heard the case or considered the record, the order, if adverse to a party other than the agency itself, shall not be made until a proposed order, including findings of fact and conclusions of law, has been served upon the parties and an opportunity has been afforded to each party adversely affected to file exceptions and present argument to the officials who are to render the decision."

116 Or App 489> "The statutory language does not specifically provide for successive hearings on the same issue, but the language does imply that such hearings were contemplated at the time of legislative enactment. The insurer's mandate that it *maintain* a premium audit program, that the program be *continuing*, and that the purpose of the program be the achievement of equitable premium charges to employers, furnishes a clear inference that the Legislature intended that the employer retain the right to appeal the results of audits for each policy year and each insurer.

"Additional evidence of the repetitive nature of the hearing right is the statement in ORS * * * 737.318(4) that all premium audit disputes in existence on July 20, 1987, regardless of the policy year involved or the date of billing, fall within the jurisdiction of the premium audit billing hearing process.

"Issue preclusion does not apply in the final premium audit billing appeal process." (Emphasis in original.)

We agree with DIF's interpretation. Issue preclusion does not prevent it from considering the estoppel claim.

Petitioner assigns error to DIF's conclusion that equitable estoppel does not bar SAIF from collecting the additional premium.⁴ Petitioner first claims that DIF incorrectly included intentional fraud as an element of equitable estoppel. The elements of equitable estoppel were discussed in *Coos County v. State of Oregon*, *supra* n 4, 303 Or at 180:

³ ORS 737.318 provides, in part:

"(1) A workers' compensation insurer shall *maintain* a premium audit program to aid in achieving equitable premium charges to Oregon employers and for the collection of credible statewide data for ratemaking.

"(2) The director shall prescribe by rule a premium audit program system for workers' compensation insurance.

"(3) The premium audit system shall include provisions for:

"* * * * *

"(b) A continuing test audit program providing for auditing of all insurers;

"(c) A continuous monitoring of the audit program system pursuant to ORS 737.235;

"(d) An appeal process pursuant to ORS 737.505 for employees to question the results of a premium audit; and

"(e) Civil penalties pursuant to ORS 731.988 for violations of prescribed standards of the premium audit system.

"(4) Notwithstanding ORS 737.505, the provisions of this section apply to all premium audit disputes between employers and insurers in existence on July 20, 1987, regardless of the policy year involved or the date of the final audit billing." (Emphasis supplied.)

⁴ *Coos County v. State of Oregon*, 303 Or 173, 181, 734 P2d 1348 (1987), says:

"We have recognized that an estoppel may be raised against government entities, subject to certain specific limitations."

No party contends that estoppel may not be raised against SAIF because it is a government entity or was performing a government function at the time of its representations and we do not decide those issues. SAIF acknowledges: "In matters involving audit and assessment of premium, SAIF's authority is no different from that of a private carrier."

"The elements of equitable estoppel in Oregon were set out by this court in *Oregon v. Portland Gen. Elec. Co.*, 52 Or 502, 528, 95 P 722 (1908):

"To constitute estoppel by conduct there must (1) be a false representation; (2) it must be made with knowledge of the facts; (3) the other party must have been ignorant of the truth; (4) it must have been made with the intention that it should be acted upon by the other party; <116 Or App 489/490> (5) the other party must have been induced to act upon it: *Bigelow, Estoppel* (5 ed.), 569, 570.'

"Courts generally have held that the misrepresentation must be one of existing material fact, and not of intention, nor may it be a conclusion from facts or a conclusion of law. *Everest and Strode, The Law of Estoppel* 251 (3d ed 1923). The party seeking estoppel must demonstrate not only reliance, but a right to rely upon the representation of the estopped party. *Marshall v. Wilson*, [175 Or 506, 518, 154 P2d 547 (1944)]. Reliance is not justified where a party has knowledge to the contrary of the fact or representation allegedly relied upon. *Willis v. Stager*, 257 Or 608, 619, 481 P2d 78 (1971). The facts creating an estoppel must be proved by a preponderance of the evidence. *McKinney v. Hindman*, 86 Or 545, 551, 169 P2d 93 (1917)."

Fraud is not an element of equitable estoppel, and the record does not indicate that DIF required petitioner to prove fraud.

Petitioner also argues that substantial evidence does not support DIF's conclusion that petitioner failed to establish the knowledge element of equitable estoppel, i.e., that SAIF knew that the flat expense allowance was subject payroll. The order says:

"No evidence was received indicating that SAIF had knowledge that Petitioner's flat expense allowances were not eligible for exclusion from subject payroll. No evidence was received that SAIF was aware of the method by which Petitioner had calculated the flat expense allowances or how Petitioner paid this allowance prior to the time of the final premium audit. Accordingly, Petitioner failed to prove its equitable estoppel theory because it failed to prove Respondent acted with knowledge of the fact that its flat expense allowance was subject payroll." (Emphasis supplied.)

We review for substantial evidence to support DIF's findings. ORS 183.482(8)(c). Petitioner contends that, contrary to DIF's language, it offered extensive evidence of SAIF's knowledge.⁵ Respondents argue that DIF could have <116 Or App 490/491> disbelieved the evidence because the witnesses, who were company officials and a former SAIF employee, were biased and SAIF rebutted their testimony.

⁵ We summarize petitioner's evidence: Bennett, SAIF's former audit manager, testified that he knew that petitioner's former insurers had permitted the exclusion; that, in May or June, 1985, he told Bruer, one of petitioner's owners, that SAIF would allow the exclusion; that he had reviewed petitioner's books, knew how it calculated and paid the truck allowance and had told petitioner that the method satisfied SAIF; that he upheld the truck rent policy, because he felt that SAIF had received a fair premium and that he sent a letter to petitioner's owner confirming the propriety of the truck rent exclusion so that petitioner would be protected if SAIF audited it. The owner corroborated Bennett's testimony about his representations.

Petitioner is correct that it introduced evidence sufficient to support a finding that SAIF knew about petitioner's method of calculating the allowance and knew that the allowance was subject payroll and still approved the exclusion before the audit. We cannot tell from the order whether DIF disbelieved petitioner's evidence, because the order makes no credibility findings or other findings to support that inference. We cannot tell whether DIF meant only that petitioner failed to meet its burden of proof.

We faced a similar problem in *Rennick v. Jackson & Coker*, 95 Or App 72, 767 P2d 478 (1989), where the trial court, at the close of the evidence, struck a claim for lost profits on the ground that the evidence would support only speculation, not a finding of fact, on the issue. We concluded that there was sufficient evidence to support a finding and remanded, because we were unable to determine whether the court's action was correct:

"Plaintiffs contend that the trial court ruled as a matter of law that their evidence was insufficient and that that was error because they offered some evidence that net profits would have been earned. See *Husky Lbr. Co. v. D.R. Johnson Lbr. Co.*, 282 Or 481, 487-88, 579 P2d 235 (1978); see also *VonRavensberg v. Houck-Carrow Corp.*, 60 Or App 412, 416-17, 653 P2d 1297 (1982). We agree with plaintiffs that there was sufficient evidence to permit a finding that some net profits would have resulted from the employment of a physician. We are unable to determine from the trial court's order whether it erroneously granted defendant's motion to strike as a matter of law or whether, sitting as factfinder, it was simply unpersuaded by the evidence. Because it is unclear, we remand for further proceedings." 95 Or App at 74.

Similarly, we cannot determine whether DIF rejected the evidence of SAIF's knowledge as a matter of law, whether DIF was simply unpersuaded by it or whether DIF erroneously overlooked it. ORS 183.482(8)(c) requires a <116 Or App 491/492> remand to permit DIF to make findings about the issue of SAIF's knowledge. Depending on its findings on that and the other contested factual issues,⁶ DIF may reach the same or a different ultimate finding on the estoppel claim and may adhere to or modify its present disposition, as it deems appropriate. ORS 183.470(2).

Reversed and remanded for proceedings not inconsistent with this opinion.

⁶ Because we hold that DIF did not resolve the equitable estoppel issue, we do not reach the question of whether DIF correctly determined that truck rental should be included in payroll if equitable estoppel does not apply.

Cite as 116 Or App 498 (1992)

November 18, 1992

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of James L. Burris, Claimant.

JAMES L. BURRIS, Petitioner,

v.

SAIF CORPORATION and PHOTOCRAFT, INC., Respondents.
(90-07378; CA A71218)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 4, 1992.

Cynthia Cumfer, Portland, argued the cause and filed the brief for petitioner.

Michael O. Whitty, Special Assistant Attorney General, Salem, argued the cause for respondents. With him on the brief were Charles S. Crookham, Attorney General, and Virginia L. Linder, Solicitor General, Salem.

Before Richardson, Presiding Judge, and Deits and Durham, Judges.
 DURHAM, J.
 Affirmed.

116 Or App 500> Claimant seeks review of an order of the Workers' Compensation Board that denied his claim for an occupational disease. We affirm.

Claimant developed symptoms of multiple sclerosis in 1973. He also experienced migraine headaches and right leg numbness. Three years later, he began to work for employer. In 1977, during a leave from work, his symptoms recurred, and he experienced fatigue and blurred vision. In October, 1978, he quit work because his symptoms had made it too difficult for him to perform. The symptoms dissipated in 1981, and he returned to part-time work for employer. Later, he resumed full-time work and continued until 1990, when his symptoms became disabling. He quit and filed a claim for compensation, asserting that work-related physical activity and mental stress had worsened his underlying condition. Employer denied the claim on the basis that his condition was unrelated to the work. Claimant requested a hearing. The Board found that he had failed to prove that his work was the major contributing cause of a worsening of his condition or its symptoms.

Claimant assigns error to the Board's conclusion that this is an occupational disease claim. He acknowledges that he has multiple sclerosis and that his symptoms have gradually become more diverse and severe. He asserts, nonetheless, that he has an injury. There is substantial evidence in the record that his condition arose gradually, not suddenly. *Morrow v. Pacific University*, 100 Or App 198, 201, 785 P2d 787 (1990), indicates that a chief characteristic of an occupational disease is that it is gradual rather than sudden in onset. Moreover, because claimant alleges that the worsening of his illness was caused by on-the-job stress, his claim must be treated as an occupational disease. *SAIF v. Hukari*, 113 Or App 475, 480, 833 P2d 1307 (1992).

Claimant also argues that the Board erred when it held that he is making a mental stress claim. ORS 656.802(1)(b).¹ He asserts that that subsection applies only to <116 Or App 500/501> mental disorders. At the hearing, he argued that the multiple sclerosis is compensable, because physical and mental stress at work caused it to worsen. The Board correctly ruled that a stress-caused physical condition is compensable, if at all, under ORS 656.802(1)(b). *SAIF v. Hukari*, *supra*, 113 Or App at 480. It held that claimant has not proved that he has a generally recognized mental disorder, ORS 656.802(2)(c), or that his physical activities at work were the major contributing cause of the worsening of the multiple sclerosis. ORS 656.802(2). Claimant does not challenge the Board's conclusion that he failed to meet his burden on those issues.

Affirmed.

¹ ORS 656.802(1)(b) provides:

"As used in this chapter, 'occupational disease' means any disease or infection arising out of and in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, and which requires medical services or results in disability or death, including:

"* * * * *

"(b) Any mental disorder which requires medical services or results in physical or mental disability or death."

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